

**Language Diversity in the Public Health Sector in the Cape  
Unicity:  
Policy and Practice**

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## Declaration

I, the undersigned hereby declare that the work contained in this thesis is my own original work and that I have not previously in entirety or in part submitted it at any university for a degree.

**Signature**



**Date**

27.02.2006

## SUMMARY

The purpose of this study is to study language diversity in the public health sector in the Cape Unicity area. The recent introduction of a multilingual policy is compared to practice in the health sector. This is done in order to draw similarities and differences regarding a gap between policy and practice. Five health facilities in the Cape Unicity were approached. Twenty-five respondents were sampled: doctors, nurses, administration or management officials, patients, and official interpreters where possible. To conclude, the findings suggest a significant gap is evident between policy and practice in each of the five health facilities. However, the gap appears to differ in scope for some health facilities due to certain factors. Subsequently, a number of recommendations are proposed.

## OPSOMMING

Die doel van hierdie studie is om taaldiversiteit in die publieke gesondheidsektor in die Kaapse Unistad-gebied te bestudeer. Die onlangse instelling van 'n veeltalige beleid word met die praktyk in die gesondheidsektor vergelyk. Dit word gedoen om ooreenkomste en verskille met betrekking tot 'n gaping tussen beleid en praktyk te identifiseer. Vyf gesondheidsfasiliteite in die Kaapse Unistad is genader. Vyf-en-twintig respondente het deelgeneem: dokters, verpleegkundiges, administratiewe of bestuursamptenare, pasiënte en amptelike tolke waar moontlik. Ten slotte dui die bevindinge op 'n beduidende gaping tussen beleid en praktyk in elkeen van die vyf gesondheidsfasiliteite. Dit kom egter voor asof die gaping in sommige gesondheidsfasiliteite as gevolg van sekere faktore in omvang verskil. Gevolglik word 'n aantal aanbevelings gemaak.

## ISISHWANKATHELO

Injongo yoluphando kukufunda ngokusetyenziswa kwelwimi ezahlukeneyo kumaziko ezonyango eKapa. Okukwaziswa kutsha kwalenkqubo yeelwimi ezininzi kutholekiswa indlela ekudla ngokugqutywa ngayo kumaziko ezempilo. Yenzelwe okokuba kulinganiswe umsantsa wezinto ezifanayo nezingafaniyo phakathi kwenkqubo nendlela ekudla ngokugqutywa ngayo. Amaziko amahlanu ezempilo esixeko seKapa elimanyeneyo aye ahanjelwa. Abantu abangamashumi amabini anesihlanu kudliwene nabo indlebe ukuquka Oogqirha, abongikazi, Abaphathiswa okanye abaphathi, Izigulane kunye Neetoliki. Ukuqukumabela kuye kwafunyaniswa okokuba kunomsantsa obalulekileyo obubungqina phakathi kwenkqubo nendlela ekuqhutywa ngayo kulo ngalinye kula mahlanu amaziko ezempilo. Nangona kunomsantsa obonakalayo kumaziko ezempilo. Kamva inani lomakwenziwe luceliwe.

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**LIST OF ABBREVIATIONS**

CHC	Community Health Centre
CS	Community Service
GSH	Groote Schuur Hospital
HDI	Human Development Index
HHH	Hottentots Holland Hospital
NLPF	National Language Policy Framework
NLS	National Language Service
OCM	Outline of Cultural Materials
PANSALB	Pan South African Language Board
PDI	Previously Disadvantaged Individuals
PGWC	Provincial Government of the Western Cape
PHC	Primary Health Care
RCH	Red Cross Hospital
TBH	Tygerberg Hospital

# **1. Chapter One: Introduction**

## **1.1 Statement of purpose**

The purpose of this study is:

- To investigate language diversity in the public health sector in the Cape Unicity.
- To investigate language practice in public health facilities in the Unicity through participant observation by the researcher;
- To compare policy and practice at public health facilities in order to determine the gap between the two. These gaps may be reflections of language barriers between health professionals, patient and interpreter;
- To inform policy makers of the daily realities of health professionals and patients who use public health services; and
- To recommend improvements in both policy and related practice.

## **1.2 Rationale of the study**

Based on the above-mentioned it is therefore necessary to undertake the study. There has been increased pressure on the Western Cape health services because of rapid migration of mainly monolingual Xhosa-speakers from the Eastern Cape as well as foreign African refugees. This is significant in the wake of rolling out a new policy aiming to reflect and accommodate the diversity of the province.

There is a need for 'policy makers to be informed and then adapt to the realities or the context of the people they serve' (De Klerk & Barkhuizen, 2001). Further research is required to identify the potential gap between service provision and the needs of public health to which the majority of the poor (including the unemployed), working class has access. If the relevance of multilingualism in the implementation of the policy and its practical use in health services are addressed, necessary attention should be directed towards the public health sector where the state plays a direct role in its interaction with civil society.

The research therefore challenges the lack of attention that is given to issues of language diversity and language policy in health care (Foster, Freeman &

Pillay, 1997). More significantly, 'there is a growing concern that the gap between public policy (what government values and identifies as its programme of governance) and practice (what government is seen to be doing)'<sup>1</sup> is increasing. Thus, this study conducted in the Western Cape is a serious attempt to contribute towards 'policy improvement', particularly where implementation is concerned (Pretorius, 2003: 6).

The literature on the subject can also be expanded, contributing to the scientific community particularly in the field of language, multiculturalism, identity and policy development and social health perspectives. By conducting research in a field<sup>2</sup> where little research has been done, it could reasonably be expected to learn a great deal, as well as from the designs and methods (Mouton, 1996:120). Moreover, the thesis will serve as a potential 'monitor' for policy-makers, planners and implementers to continuously address and improve foreseeable shortcomings when implementing policy initiatives, mainly in the health sector.

### 1.3 Framework of chapters

After having stated the purpose of the research, a summary of each chapter of the argument is presented. The opening chapter explains the purpose of the research, which examines multilingualism in terms of its policy application in practice. The context is investigated in terms of the health institutions situated in the Cape Unicity. The outcome is to identify the potential gap informed by practice when the policy is implemented.

In *Chapter two*, the main concepts are discussed by defining language, and language in relation to diversity and ethnicity, power and identity. Moreover, concepts such as health, the public health sector and the relations between policy and practice are clarified. Accordingly, various theoretical contributions ranging from Habermas, Giddens and Foucault to other writers, concerning language and diversity relating to power are discussed.

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<sup>1</sup> See *Politeia*, 2003, 22(1): 3.

<sup>2</sup> Language studies in the health field, from a South African perspective.

*Chapter three* discusses the context concerning the above-mentioned concepts. The main themes, language and public health, are discussed in three contexts; namely the general South African context, the Western Cape and the Cape Unicity region. *Chapter four* focuses on methodology and the research design. The research is based on a qualitative approach and the chapter will look at the methodology used to obtain valid and reliable data. However, conducting the research was not easy. Accordingly, the research shortcomings are identified, which will include details of my experiences doing the fieldwork.

*Chapter five* identifies the research results from the health sector. The research results concern the respondents' view of the policy, as well as observations on the policy implications in health. Information on practice will be summarised for each health facility and thereafter compared. This is done in order to determine the language competency for each health facility and the gap between the policy objectives and the actual realities in practice. Accordingly, problematic factors in the health settings are summarised and the health settings are compared in terms of the attitudes and perceptions concerning policy, language and diversity issues. This will concern the public health sector's accommodation of the policy.

Lastly, *Chapter six* provides a summary of the most important themes. Accordingly, research limitations, a recommendation for the policy in progress are proposed as well as prospects for future research. A detailed bibliography collected over a period of three years on the subject is included. An appendix is attached containing covering letters from the fieldwork, an ethical protocol and two interview guides.

## **2. Chapter Two: Basic Concepts**

### **2.1 Introduction**

The chapter aims to clarify the key concepts that are relevant to the purpose of the research, namely, investigating the multilingual policy and implementation in the public health sector in the Cape Unicity area'. Accordingly, the concept 'language' is clarified and furthermore explained in its relationship to power, identity, as well as ethnicity. Language diversity is then discussed in terms of urbanisation and globalisation, in association with language and power. This is done in order to be able to understand or draw meaningful conclusions of the study' (Babbie & Mouton, 2001: 99).

Section 2.2.1 in particular, will address language and diversity. Sections 2.2.2 and 2.2.3 will discuss language and its associations with power and identity. This will be done in section 2.2. Since language policy and practice will be analysed within the public health sector, there is a need to clarify public health as a system and institution. Moreover, the discussion of the health system will serve as an example for the clarification of language, language diversity and its relationship with power and identity in section 2.2 above. This is then discussed in section 2.3. Next, public policy and its relation to practice will be discussed as well as the consequences of a gap between policy and practice. This is presented in section 2.4. The above-mentioned concepts will then be used to identify and explain why language diversity in practice in the public health sector of the Cape Unicity, occasionally deviates from the stated policy.

## **2.2 Language**

### **2.2.1 Language and diversity**

Language can be defined as a 'structure, being more than a whole with many parts. It is a structure of meaning composed of parts such as words, sentences, punctuation, nouns, verbs...and figures of speech (Froman, 1992: 11). As a structure...that is, sentences in the form of subject and predicate, the world is being described and explained in it (1992: 11). In other words, language constructs the social realities of our world, it is intrinsic to who we are as human beings. (Seidman, 1998). Language therefore defines human beings, our

desires, and needs and attributes meaning to our world and what we construct as reality in it. Accordingly, Robey (1987) states:

“Words articulate our experience of things; they do not just express or reflect reality. They give form to objects...and without language and other sign-systems; everything would be...a confusing jumble of ideas. It is words that inevitably determine the meaning of things (sources or objects)” [Cited in Moleleki, 2003:6].

Yet, how do we construct and make sense of our realities? Through our ideas or mental constructs, we give form to words or objects that may consist of symbols and signs from one social context to another (Hayakawa, 1954: 254-260). The objects, with which we make reality, are at the same time given new meaning and created and given by humans (Hayakawa, 1954 & Froman, 1992). Consequently, words become concepts or symbols wherein knowledge is created since humans make sense of reality by knowing, understanding and interpreting it through language (Hayakawa, 1954 & Froman, 1992). It is in the social system where we construct and make meaning of our realities. Similarly, social systems are created in an environment where humans interact with one another.

Giddens refers to the idea of systems as the pattern of social relationships that can only exist when produced and reproduced over space and time through humans interacting with one another (Layder, 1994). Thus, social systems and institutions and other social structures are not independent of individual actions. When we construct our realities, it can be regarded as a form of action. Stated differently, human behaviour or action is part of reality in the sense that words and concepts can be used to construct reality. Our conceptualisation of words and symbols construct knowledge and our interests and ideas and are communicated to other humans by what Habermas terms making ‘valid claims’. Validity claims are made in ordinary conversations, where people make rational claims about the world including claims about social rules (Layder, 1994; Seidman, 1998 & Froman, 1992). In other words, as we interact, we organize norms, routines and regulation, or rules of conduct in our everyday structures such as the workplace.

Similarly, 'language that harbours linguistic meanings also plays a major role in organizing the self, social institutions and the political sphere' (Layder, 1994 & Seidman, 1998). Through language, knowledge is created and recreated, which in turn produce our social structures such as work, communication or power dynamics, social systems that entrench institutions such as health and education. According to Giddens, social systems are considered a routine feature of society as they are continually reproduced in people's behaviour over time (Layder, 1994 & Seidman, 1998). For example, medical students are taught the moral and technical knowledge<sup>3</sup> of being a professional doctor or nurse in health institutions like a tertiary level hospital. Such knowledge is then passed on to the next generation of aspiring health professionals. In such instances, people are socialised into producing such knowledgeable skills and in doing so, institutions are reproducing the rules and resources through linguistic communication (Seidman, 1998: 140).

Through such communicative action, the everyday realities of the institution or organisation consequently become 'ordered' or categorised in structure. Stated differently, a division of labour is generated when health professionals are taught the norms, expectations and social relationships given in face-to-face interaction (1998: 138). However, Habermas argues that such existence of reality cannot exist without individuals being able to reach consensus in the interaction process (Layder, 1994). Similarly, humans ought to have shared understanding or agreement when trying to convince others, since society is dependent on people functioning as a co-operative group to produce the material means of life (Cornforth, 1965). If a person resists or disagrees with a claim then he or she has made sense of their own reality from the other individual or group (Froman, 1992: 13). For example, doctors may generally diagnose and interpret a Westernised view of a symptom of fits as epilepsy, whereas a Xhosa-speaking health professional or patient could alternatively define that same symptom as a cultural form of 'demonic possession' or witchcraft (Tjale & De Villiers, 2004; Swartz, 2001 & Foster, et al., 1997).

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<sup>3</sup> Moral knowledge consists of our ideas about social norms, justice, identities and community. Technical knowledge alternatively entails the formulation of empirical-analytical expertise in work (Layder, 1994: 188, 189).



People derive their own worldviews through language and may order their perspective differently from the other individual or groups views<sup>4</sup>. As people are ordered or categorised differently according to the meanings of the world, they interpret themselves distinctly from each other (Froman, 1992, Poltzer, 2002, Layder, 1994 & Seidman, 1998). In terms of language, each language group within a work structure for instance, obtains a shared consensus of themselves and the real world. In turn, each group undergoes a process of enculturation or socialisation where culture is transmitted from one generation to the next through their shared language (Tjale & De Villiers, 2004: 67). In effect, the situation where three or more such language groups exist in the same space is known as multilingualism or language diversity (Department of Arts and Culture, 2002). Moreover, what could also be emphasised is the dimension of language as a structure and relations of power and difference that is manifested.

### **2.2.2 Language and power**

Foucault and various poststructuralists stress that languages, or what they would call discourses<sup>5</sup> are not to be regarded as a 'neutral medium of expression' (Layder, 1994: 97). Instead, languages are expressions of power relations and reflect practices and positions that are bound to them. Similarly, power involves the control of languages and power is created and operates in language(s) [Froman, 1992: 210, 211]. Hence, if language is a structure wherein ordered realities of the world exist then a "culture of power" exists (Froman, 1992; Kennedy & Minami, 1991). To illustrate, when a nurse or patient enters the hospital and is assigned into subordinate positions<sup>6</sup> and roles by other work groups, the power effects are then evident.<sup>7</sup>

Although Foucault only focuses on the effects of power, Giddens provides sufficient explanation as to from where and how power stems (Layder, 1994).

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<sup>4</sup> See Poststructuralist emphasis on 'language and relations of difference' on Derrida and Saussure's claim in Seidman (1998). They state "words and concepts are meaningful in a discourse, in ways that they differ from other words and concepts to another discourse (217).

<sup>5</sup> A discourse refers to anything that can be thought (ideas), written or spoken about a particular object such as a car, or topic or specialised area of knowledge such as medicine or law (Layder, 1994: 97).

<sup>6</sup> The subordinate position implies where one has a function to perform within certain constraints and limited to various kinds of activities (Froman, 1992: 210, 211).

<sup>7</sup> See Foucault in Layder (1994) and Seidman (1998).

He argues that “all human action involves power”, which is the capability to produce an effect (1994: 137). Giddens defines power as ‘the ability to make a difference in and on the social world that is, changing the circumstances in which one finds oneself’ (Layder, 1994: 137). Stated earlier, Habermas argued that human action is embedded in the process of communication and social interaction. In effect, the outcome is the creation of ordered views of reality such as the division of labour and hence, the identities of socialised individuals or groups in their personal view of reality (Layder, 1994; Seidman, 1998; Joseph, 1992 & Kennedy & Minami, 1991).

Moreover, the doctor’s position is socialised or educated into being able to conduct the practice of medicine. Here, the doctor controls the technical and moral knowledge in being able to treat and heal the patient. However, in the socio – political context where provision has to be made for marginalized or ethnic minorities, the doctor is unable to maintain autonomy over the interaction if he or she cannot understand and control the language. If there is a language barrier then the doctor is constrained in his or her role, which is to treat and cure the patient efficiently (Iezzoni, O’Day, Killeen & Harker, 2004; Kennedy & Minami, 1991; Bowen, 2003). Thus, the doctor’s capacity to treat the patient is only possible and dependent on someone who can decode or interpret the language preferred by the patient (Machet, 2002). The doctor’s uncertainty or inability to retain and disseminate information with the patient is an indication of the loss of power, which therefore supports Foucault’s establishment of the link between knowledge (and discourses) and power (Layder, 1994: 97-104).

Giddens accordingly, relates to the power relations where the doctor’s power or influence in his or her role is somewhat dependent on the power of one who has the resources to decode the language in a rational manner (Layder, 1994: 137). However, what is important here are the relations of power and identity, which are both implicit and explicit in language (Kennedy & Minami, 1991; Froman, 1992).

### **2.2.3 Language and identity**

Identity is regarded as a multifaceted concept in the academic world (Gaudelli, 1999). However, identities are best defined as “social...and narrative options

offered by a particular society in a specific time and place to which people appeal in order to self – name or self – categorise, and claim social spaces and rights (Leibowitz, Adendorff, Daniels, et al., 2002: 3). Similarly, the 'social and narrative' options imply shared experiences among individuals in social interaction, which becomes meaningful to the individual or group (Espejo, 2000: 952, Alexander et al., 2001; Castells, 1997). The shared experiences are the norms, values, traditions, attitudes and beliefs, which are the cultural features that help, define and characterise the individual or group (Kennedy & Minami, 1991).

The specific identity of the group or individual is expressed in the form of signs and symbols, depending on the context (Cornforth, 1965). Hence, the status of language in its use is not solely an acceptable linguistic condition but also to acknowledge the culture implied by it (Moleleki, 2003: 7). For example, a deaf person will ascribe him or herself to the Deaf community since they altogether identify themselves as deaf because they speak sign language (Holtzhausen, 2004: 1). The sense of identity in "being deaf" within a particular time and space, may or may not ultimately surpass all other social and ethnic forms of identity (Holtzhausen, 2004). When a person identifies oneself as a deaf person in a particular social space, it could be interpreted as part of the person's cultural or social identity (Kennedy & Minami, 1991; Polzer, 2003). A social identity is "the aspects of an individual's self-image that derive from social categories to which he or she perceives themselves as belonging" (Kennedy & Minami, 1991: 357).

By communicating in Sign Language, it then becomes the marker in which others are aware of the person as 'being deaf' as well as empowering him or her to communicate effectively with other deaf speakers in sign. However, in particular situations individuals have multiple identities in which one identity may be primarily meaningful above other identities (Castells, 1997; Polzer, 2003; Alexander, 2001, Bekker, Cornelissen & Horstmeier, et al, 2000). Similarly, a doctor may have a strong ethnic identity at home in terms of his or her religious beliefs, gender or even speak a language that may affirm his or her culture, but in the hospital, his or her role as a doctor may be primarily

identified in the workplace (Polzer, 2003). In the work culture of nursing, nurses may identify themselves differently from doctors and other caretakers in terms of their shared beliefs, knowledge, norms, traditions and forms of social relations in patient care (Bekker & Prinsloo, 1999; Joseph, 1994 & Polzer, 2003).

Similarly, ethnicity also defines one's cultural identity if people's sense of shared meanings and experiences is along the lines of religion, race, language and gender (Alexander, 2001 & Bekker, 2001). In addition, these ethnic 'markers' serve as power constructs that may be used by those to gain access to potential resources in the broader political spectrum (Alexander, 2001: 150). However, Alexander significantly underlines the central role that language has played in conceptualising identities in the socio – political arena (2001: 141, 142).

### **2.3 The social construction of health**

The public sector can be defined as comprising service providing institutions, which fall under the government (state) and whose services are rendered by various departments (Demone Jr & Harshbarger, 1974 & Foster, et al., 1997). A particular department for example is the health sector. In Parsonian sociology, health is viewed as a beneficial resource and non-negotiable requirement and thus essential for the normal functioning unit for the individual and society (Honneth & Joas, 1988; Fox, 1982 & Cox & Mead, 1975). In addition, health promotion is not solely based on the 'mere absence of physical and psychological disease or illness, but more importantly on social and environmental factors (Hancock, 1999: viii & Moore, 1999).

Durkheim demonstrates the social relevance of health in his work, *'Suicide'* where he associates the relationship between social facts and suicide (Joseph, 1994: 75-77). In his example of anomic suicide, the individual experiences a state without norms (the clashing or absence of norms) resulting in the individual feeling isolated or alienated. The state without norms might occur in events of social change (such as urbanisation or globalisation) where the individual's identity is constrained. Hence, Joseph argues that the social

construction of illness stems from the social context from which all knowledge emerges (1994: 80).

In medical sociology, the definition of the health institution or organisation is categorically aligned with Goffman's (1968) idea of the 'total institution'. The 'total institution' is "a place where a large number of people come together and are relatively cut off from the wider society. Furthermore, the aim of the health institution is to 'protect, define, enhance and maintain the personal well-being of people by influencing individuals' behaviour and characteristics' (Austin, Skelding & Smith, 1977 & Hasenfeld, 1983). Here, the socialisation process for health professionals, particularly doctors and nurses is evident (Joseph, 1994, Cox & Mead, 1975). When medical students and even patients are admitted they are introduced into a new social system (Joseph, 1994). The health system is given form in the experience of social interaction and then the transference of patterned or structured social relationships.

In social interaction, people accept the given claims about the realities of the world, which in turn becomes objectified into a certain view of the world. Consequently, an ordered view of the world becomes realised in the form of routine behaviour; these norms, values, ethics and traditions are established in the field and implemented in the medical practice of service provision, consultation and patient care (Layder, 1994 & Seidman, 1998). This hierarchy or division of labour is apparent where people are institutionalised into specific labour groups. Consecutively, the managers, doctors and nurses are socialised into assigned roles and codes of conduct in which they are expected to behave. Even patients are given a 'sick role' when admitted to the hospital or clinic where they are entitled to withdraw from normal social functioning and 'must want to get healed as soon as possible' (Joseph, 1994: 37, 38). In turn, the doctor is assigned the professional role where he or she is guided by the professional code of conduct to apply highly skilled knowledge of treating the problem of illness (1994: 38). According to Goffman (1969), the role of the doctor should not be seen as a mere individual, but as a socialised actor with

other actors as the nurse and the given role<sup>8</sup> of the patient on stage (1994: 46). Accordingly, the role of each labour group and patient should be exercised in a detached and scientifically rational manner in order to produce and maintain bureaucratic efficiency in the institution (Austin, Skelding & Smith, 1977; Demone Jr & Harshbarger, 1974 & Joseph, 1994).

Here, each socialised work role has a different view of reality, where one group is typically granted a higher status in their work role than the other group. For example, the doctor is seen as the 'curer' in health culture and therefore his or her role is the most important in patient treatment (Joseph, 1994). Moreover, the doctor occupies the position of authority in relation to the patient and is granted greater autonomy in professional practice [than the nurse] (1994: 38). The doctor also assumes accountability for the decisions and direct consequences of the patient (Cox & Mead, 1975: 88). Although the doctor may also receive equal status with management, in reality most doctors do not want to be managers and rather seek clinical freedom (1994: 31).

Thus, the power arrangements are clear in these structured social relations, which some argue make effective and collaborative communication between doctor and nurse problematic<sup>9</sup> (Joseph, 1994). However, the power arrangements are not solely active within the functioning of rationality of the institution. Instead, these socialised roles are also guided by [cultural] beliefs and realities (Joseph, 1994 & Tjale & De Villiers, 2004). For example, the role of the doctor is often seen as a patriarchal function in health. Here, men are considered 'rational, decisive and assertive', which is deemed to be standard in their position. Alternatively, the role of a nurse is regarded as "women's work", where she ought to be nurturing, provide loving care and passive. In the bureaucratic system, if a nurse complains to management, she may well be seen as assertive and labelled a 'troublemaker'. This may damage her career prospects and her professional identity. Hence, the interplay of power

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<sup>8</sup> Generally, people do not choose the role of being a patient. Rather, they are defined and treated as patients unwillingly. Contrary to the role of a doctor or nurse, which is normally through personal choice (Joseph, 1994: 82)?

<sup>9</sup> As emphasised by Joseph (1994), in most cases teamwork among health professionals operate smoothly, thus it would be a generalisation to give the impression that relations among them are conflict-based.

influences in relation to identities may be evident. The functional approach to these issues claims that doctor and nurse roles are complementary and interdependent. Whether power or functional relations become prominent is therefore an empirical question.

The influence of power is particularly prominent in the doctor – patient relationship (Joseph, 1994; Cox & Mead, 1975; Tjale & De Villiers, 2004; Foster, et al., 1997; Baldwin, 2003; Bowen, 2003; Doheny, 2004; Dressler, 1996 & Fehr – Snyder, 2002). In such interaction, the communication is traditionally two – way communication between doctor and patient, and if the child is a patient then it is with a family member. The doctor follows the rational procedures in the manner he or she is normally trained in their leading role such as obtaining a history from the patient, producing a diagnosis and then follows treatment, serially. However due to globalisation and urbanisation effects, societies are generally becoming culturally and linguistically diverse (Schmid, 2001; Carlsnaes & Muller, 1997; Nyamnjoh, 2003 & Bekker, 2001).

Therefore, the likelihood of a doctor meeting a patient who communicates in a different language to the doctor is highly likely (Bowen, 2003 & Baldwin, 2003). If the doctor is unable to decode or understand the language communicated to him or her, then a communication disorder is said to occur (Rees Jones, et al., 2004). In this instance, the doctor has difficulty in obtaining information in order to make a diagnosis and follow treatment.

As mentioned, the loss of information or knowledge is also an indication of the loss of power and either identity may be strained, which in this instance is the role identity of the doctor (Layder, 1994; Seidman, 1998; Joseph, 1994 & Poltzer, 2002). Consequently, the doctor is unable to be in control of the interaction and he or she may be dependent on a third person that can speak the language of the patient. [What is emphasised here is the shift in the workforce where official or ‘professional’ interpreters are introduced into the division of labour (Karliner, et al., 2004 & Moeketsi, 2000)]. Subsequently, power is transferred to the interpreter since a language barrier is involved in the doctor’s difficulty to maintain control in the interaction (Layder, 1994 & Seidman, 1998). Ironically, it is the doctor’s highly regarded social status in the



health and broader social system, which is dependent on the successful application of rational knowledge to ensure the service productivity of health in the institution (Poltzer, 2002, Miller, 1984, Bowen, 2003; Baldwin, 2003 & Tjale & De Villiers, 2004).

Thus, in the situation of language diversity the doctor's role identity is limited in its dependence on cultural knowledge and not solely on rational knowledge. However, it is only in the initiation of policy and its obligation to implement official medical interpreters that rational procedures are followed, efficient communication and service productivity is ensured in bureaucratic and rationally organised institutions (Joseph, 1994; Austin, Skelding & Smith, 1977; Demone Jr & Harshbarger, 1974; Department of Arts and Culture, 1998; Bowen, 2003; Baldwin, 2003 & De Vries, 2003).

## **2.4 Policy and Practice: the problem of implementation**

Public policy is "the guiding principles or set goals or objectives, designed [by the state] to influence and determine the decisions and actions of civil society (Bangwanubusa, 2002: 10). In the above sense, the principles or set goals and objectives are recognised social needs or solving identifiable problems, which ought to be achieved (2002: 10). Hence, the goals and nature of public policy is the state's aim to promote democracy and accommodating ethnicity in the nation – state by realising the equality of languages for representatives in civil society. As a result, these representatives may equally benefit or remain accessible to health and other social services. In essence, the state is then constitutionally mandated to protect and honour the autonomy of civil society by ensuring that the rights of representatives are exercised (Young, 1998; Gagiano & Du Toit, 2005; & Foster, Freeman & Pillay, 1997). In relation to policy, practice is the "action or realities concerning the implementation of the principles designed and the intervention to achieve the predetermined goals or objectives" (Bangwanubusa, 2002).

In turn, practice impacts on the social environment that bears the representatives of civil society or policy stakeholders. An example of such an environment may be in this case, the Cape Unicity's public health sector.



However, policy objectives may not always complement the shifting realities of practice since the policy may unpredictably constrain or exclude beneficiaries (Foster, et al., 1997: 30). Bangbose argues (1991) "language policies in Africa, no matter how good they are, are characterised by, among other aspects ...declaration without implementation [cited in Mutasa, 1999: 86]. This means that although policy objectives stipulate the equal promotion of the set language(s) and its use, alternatively in practice some languages are devalued in status (Mutasa, 1999). This is known as the problem of implementation where a gap is likely to occur between set policy objectives and implementation (Pretorius, 2003). However, to reduce the gap policymakers should be informed of the attitudes, perceptions and everyday realities in practice that constantly change with the social context (Pretorius, 2003).

## 2.5 Conclusion

This chapter clarified the basic concepts presented in the purpose of the research. Three themes have been identified. Firstly, in section 2.2 language is discussed in terms of its association with the concept of power, ethnicity and identity. The contributions of various theorists and academics such as Foucault, Habermas, Derrida and Giddens among others are identified. Accordingly, language(s) is regarded as a power – related construct, which is necessary for communication and consecutively, the creation of our social realities. Stated differently, people make meaning of their own views and experiences of the world in the midst of social interaction.

Secondly, the above-mentioned clarification of language(s) is attributed to the public health sector in section 2.3. The social construction of illness and health as a [social] system is also explored. Thirdly, section 2.4 discusses the relationship between [language] policy and practice specifically in the public health sector. Subsequently, the failure to address policy implementation effectively results in a gap between policy ideals. This is addressed in Chapter five.

The clarification of the above-mentioned concepts provides insight into the purpose of the study. The fifth primary concept is the '*Cape Unicity*' region,

which is the 'map' or physical context in which this discourse takes place and is discussed in the next chapter.

## **CHAPTER THREE: FROM THE GENERAL, TO THE SPECIFIC – THE SOUTH AFRICAN CONTEXT**

### **3.1 Introduction**

The chapter outlines the three main demographic contexts, which are the broader South African, the Western Cape and the Cape Unicity area. The discussion of each context will be based on two themes, namely language and public health. This is done because both language and health policies are concurrent in national, provincial and local government legislation, namely, what functions at a national level, must also similarly function at provincial and local levels in a cooperative government.

The two themes are described by looking at language and language policy from an historical perspective in the South African context. This is presented in section 3.2 and subsection 3.2.1.1 respectively. Similarly, in the second theme, an historical perspective on public health is provided in the South African context in subsection 3.3.1. The historical view describes both former language and health policies as well as practice in South Africa.

The current context then shifts to subsections, 3.2.1.2 and 3.2.1.3 for South Africa. Here current language/health practice and policy in South Africa is discussed. The same will be done briefly for the Western Cape in sections 3.2.2 and 3.3.2. The local context is then discussed and the current language/health policies and practice of the Cape Unicity is presented. This is presented in sections 3.2.3, 3.3.2, 3.3.3 and 3.3.4.

### **3.2 Language distribution and the language policy**

#### **3.2.1 South Africa**

##### **3.2.1.1 History of language politics**

According to Werner Solars (1997), “language continues to be a blind spot in the debates surrounding cultural pluralism” [In Schmid, 2001: 10]. Similarly, language has been a debatable term in South Africa’s historical and present contexts (Finchileschu & Gugu, 1998; Bekker, 1998; Alexander, 1999; Mutasa,

1999 & Madiba, 1999). In fact, South Africa's political history has been fraught with language and language – related conflicts since the colonial period (Madiba, 1999: 74). The first language – related conflict occurred in the arrival of the Dutch in 1652 when they had linguistic problems with the Khoi and the San people (Madiba, 1999 & Mesthrie, 2002). Accordingly, the Dutch were not prepared to learn the languages of the Khoi and San and consequently, the indigenous people were forced to learn Dutch. As a result, this contributed to the loss of both Khoi and San languages (Madiba, 1999: 74, 75). Furthermore, the language contact between the Dutch and the indigenous speakers led to the development of “broken Dutch”, which partially contributed to the formation of the modern Afrikaans language (Mesthrie, 2002).

The second language – related conflict occurred between the British and Dutch (also known as Afrikaners) from the Cape to the northern Transvaal regions. The British adopted a policy of Anglicisation where English was appointed as the official language of government, law and education (Mesthrie, 2002 & Madiba, 1999). In effect, the Afrikaners were marginalized and excluded from power resources such as education and administrative systems as well as the commerce and industry (1999: 75). Thus, Afrikaner resistance to British imperialism gave rise to Afrikaner nationalism. Following the rise of Afrikaner nationalism, Afrikaans became the language of the poor as well as the growing middle – class of Afrikaners, further affected by urbanisation and industrialisation during the war period.

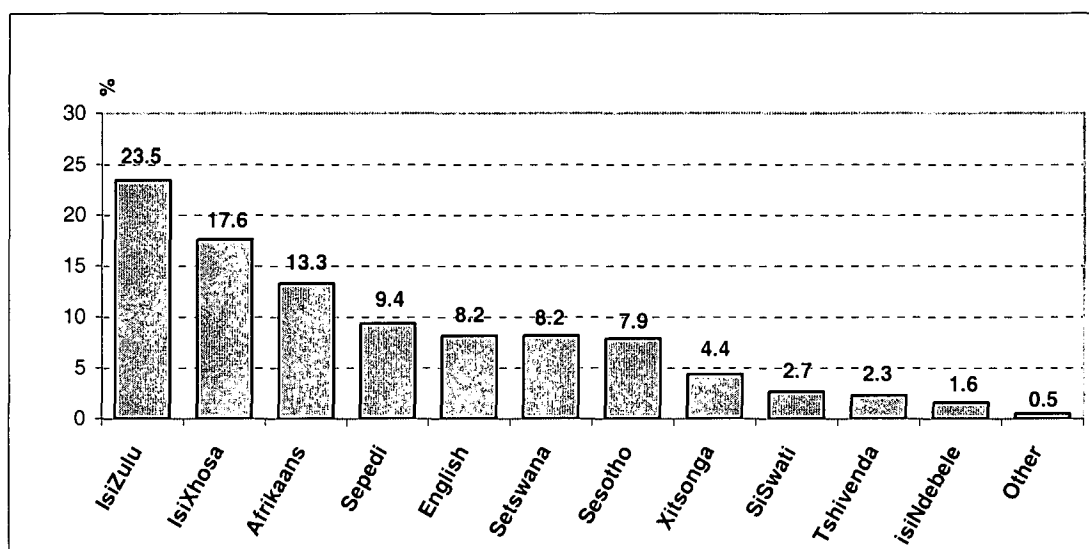
The third language conflict took place between Afrikaans and the indigenous languages between the period of 1910 and during the Apartheid regime (Kriel, 2003; Bekker, 1999 & Mutasa, 1999). Accordingly, Afrikaans and English received official status, thereby marginalizing African languages in language practice. This meant that mainly African groups were restricted access to resources, service distribution and development opportunities, which facilitated upward social mobility (Mutasa, 1999).

### **3.2.1.2 A multilingual society**

After 1994, South Africa is a society that is culturally and linguistically diverse, which is regarded as a highly valued asset in fostering national unity

(Department of Arts and Culture, 2002). Linguistically, there are approximately twenty-five different spoken languages of which only eleven have been given official status (see figure 3.1 below). Since 1995, there has been a slight increase in the percentage of people speaking African indigenous languages as their home language, and a slight decrease in the percentage of those people speaking both English and Afrikaans" (Hirschowitz, Sekwati & Budlender, 2001: 1).

**Figure 3.1: % Distribution of the South African population by language spoken at home, 2001.**



Source: Statistics South Africa 2001

There are three primary metaphorical views on multilingualism as intrinsic to nation building in South Africa. The first is Desmond Tutu's '*Rainbow nation*'. Accordingly, the 'blending of colours of the rainbow is merged with ethnic diversity into one nation, which is conceptualised as "unity through diversity"'.

Secondly there is Cashmore's (1996) '*Salad bowl*', where each ingredient is different and unique but no ingredient is less valuable than the other [on the grounds of ethnicity] in its contribution in the salad bowl (cited in Madiba, 1999: 65, 66). Close interaction and communication like cross – pollination of the salad ingredients consequently enrich integration. Hence, emphasising the public participation of all ethnic groups included the appropriation of an equal distribution of resources and power, privileges and civil rights. The '*Salad bowl*'

metaphor is more favourable compared to the much-criticised 'Rainbow nation' (1999: 65).

Thirdly, there is Neville Alexander's metaphor of the 'Garieb nation'. Our conception of a multicultural society is sufficient to describe our diversity, as illustrated by Alexander (1999). Briefly, the Garieb (formerly the Orange River) is the mainstream, which represents the nation as a whole. The river's various tributaries carry the traditional value systems, beliefs and practices of different cultures and social groups. Accordingly, these tributaries or streams differ in shape and volume, but are equally a vital contribution as the river's 'life source'<sup>10</sup>. The tributaries flow together, sometimes in conflict or in solidarity with one another and consequently influence one another in their interactions. Similarly, the mainstream and its multiple tributaries converge and influence each other simultaneously, however unpredictable they may be in relation to one another.

However, there is no dominant current and all currents that flow in the tributaries continue to dynamically transform over time in accordance with the mainstream. Moreover, diversity is valuable in the approach to overcome the barriers of inequality and to empower the previously disadvantaged. Similarly, diversity is presented in the message that languages and culture are respected; hence promoting the self-image of marginal groups (Kennedy & Minami, 1991).

Alexander also mentions the 'coca cola' stream, which conveys the influence of globalisation into its tributaries and the mainstream. Thus, if one wants to speak metaphorically of the nation, then Alexander's "Garieb nation" is more realistic. Since metaphors are embodied in human experience and everyday realities, Alexander is near accurate with reference to globalisation, which the former metaphorical views have not mentioned (Gibbs, R.W., Lenz Costa Lima & Francozo, 2004: 1). Hence, the interplay of power arrangements in the negotiation for national integration is seemingly more apparent in the construction of this metaphor (Froman, 1992).

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<sup>10</sup> Connation of water as its natural function.

### 3.2.1.3 The language policy framework

The government needed to address the inequalities of the former Apartheid language policy, which placed English and Afrikaans as the dominant languages in the socio – economic and political arena [Department of Arts & Culture, 2002]. Therefore, the present government had to respond to the constitutional challenges of addressing their linguistic and cultural diversity by introducing the National Language Policy Framework in 1998 (2002: 6). The policy framework purposely serves to cater for the harmonisation of the language policy at national, provincial and local spheres of government. Accordingly, the framework should also stipulate clear policy objectives on the status and use of indigenous languages in particular, in all nine provinces of South Africa (2002: 6).

In promoting multilingualism, the policy stipulates the use of the various languages in government structures as follows<sup>11</sup>:

- 1) As mentioned, there are eleven official languages namely; Sepedi, Sesotho, Setswana, siSwati, Tshivenda, Xitsonga, Afrikaans, English, isiNdebele, isiXhosa and isiZulu. The effective operation at all levels of government requires comprehensive communication of information, which means publishing must be conducted in all eleven official languages and, in all the official languages prescribed in the province. By legislation, all official languages must enjoy parity of esteem and be treated equally. This is done to ensure the equal access of individuals to government services, knowledge and information.
- 2) The historically diminished use and status of the indigenous languages must be recognised and the state must take practical and positive measures to elevate the status and advance the use of such languages. Accordingly, the Pan South African Language Board (PANSALB) must promote the development and use of i) all official languages, ii) the Khoi, Nama and San indigenous languages and iii) sign language.

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<sup>11</sup> See Mesthrie, 2002: 23, 24 and Department of Arts & Culture. 2002. *National Language Policy Framework: Final Draft*. Cape Town: Western Cape Provincial Department of Health.

- 3) A publication programme of functional multilingualism should be applied in national and provincial government departments in those cases that do not require publication in all the eleven official languages. Functional multilingualism refers to “the choice of a particular language(s) in a particular situation, which is determined by the context in which the language is used” (2002: 19). For example, municipalities (local) and [provincial] government departments must agree on a working language(s) for both intra and interdepartmental communication. However, the language use and preference of their residents and clients must be firstly considered.
- 4) If in cases where all eleven official languages are not published in government documents, then documents must be simultaneously published in at least six of the eleven official languages. The six languages must comprise at least one language from the Nguni group (either isiNdebele, isiXhosa, isiZulu or siSwati), at least one language from the Sotho group (either Sepedi, Sesotho or Setswana), Tshivenda, Xitsonga, English and Afrikaans. Similarly, when languages are selected from the Nguni or Sotho group, they must be constantly rotated in the publishing of government documents.
- 5) In terms of internal and external communication, the language of the citizen or client’s choice must be used for official correspondence. Furthermore, all spoken communication must be conducted in the preferred official language of the target audience. Similarly, for the purpose of conducting meetings or performing specific tasks, every effort must be made to make use of translation or interpreting services, where practically possible.
- 6) Foreign national languages that include Greek, German, Gujarati, Hindi, Portuguese, Tamil, Telugu, Urdu, and other languages commonly used by communities in South Africa, should be promoted and respected. This includes languages used for religious purposes such as Arabic, Hebrew, and Sanskrit among others. Moreover, on the international level



government communication is generally conducted in English or in the preferred language of the country concerned.

Subsequently, implementing<sup>12</sup> the policy will result in the higher demand for translation, editing and interpreting services; this will require skills training for professional language practitioners. Hence, the National Language Service (NLS) will be responsible for the management of policy implementation by coordinating the development of training programmes and operational guidelines of various language units.

### **3.2.2 Social demography and policy of the Western Cape**

The Western Cape is situated<sup>13</sup> on the south-western point of the African continent and South Africa (figure inset 3.2). The total area of the province is 129 386km<sup>2</sup>. Moreover, it is the second most prosperous province in the country following Gauteng. Its economic growth at 3.1% exceeds the national average and has the lowest percentage of poverty (20%) compared to South Africa's poverty average percentage of 48% [South Africa at a Glance, 2003-2004: 64]. Furthermore, the province has the highest literacy rate (approximately 95%)<sup>14</sup> and the lowest unemployment rate (18.4%).<sup>15</sup> The Human Development Index<sup>16</sup> (HDI) is one of the highest (0.70%)<sup>17</sup> thereby exceeding South Africa's HDI average of 0.63%.<sup>18</sup> The Western Cape currently has an estimated total of 4 524 335 million<sup>19</sup> people, which constitutes approximately 10.1% of the South African population.<sup>20</sup> The majority of the population is female (51.5%) and the Coloured population is in the majority (53.9%), followed by Black Africans (26.7%), Whites (18.4%) and Indian/Asian (1.0%) groups [Census 2001].

<sup>12</sup> See section 3.5.3, *Ibid.*

<sup>13</sup> Source: South African Yearbook 2002/2003 & [www.capegateway.gov.za](http://www.capegateway.gov.za). See inset of figure 3.2.

<sup>14</sup> Source: Statistics SA (Human development Index, 1996).

<sup>15</sup> Source: the Labour Force Survey (LFS), September, 2001 & Census 2001. Consists of the unemployment rate (strict definition) among those aged 15-65 in each province.

<sup>16</sup> Measured in terms of income, level of education and life expectancy (South Africa at a Glance, 2003/4).

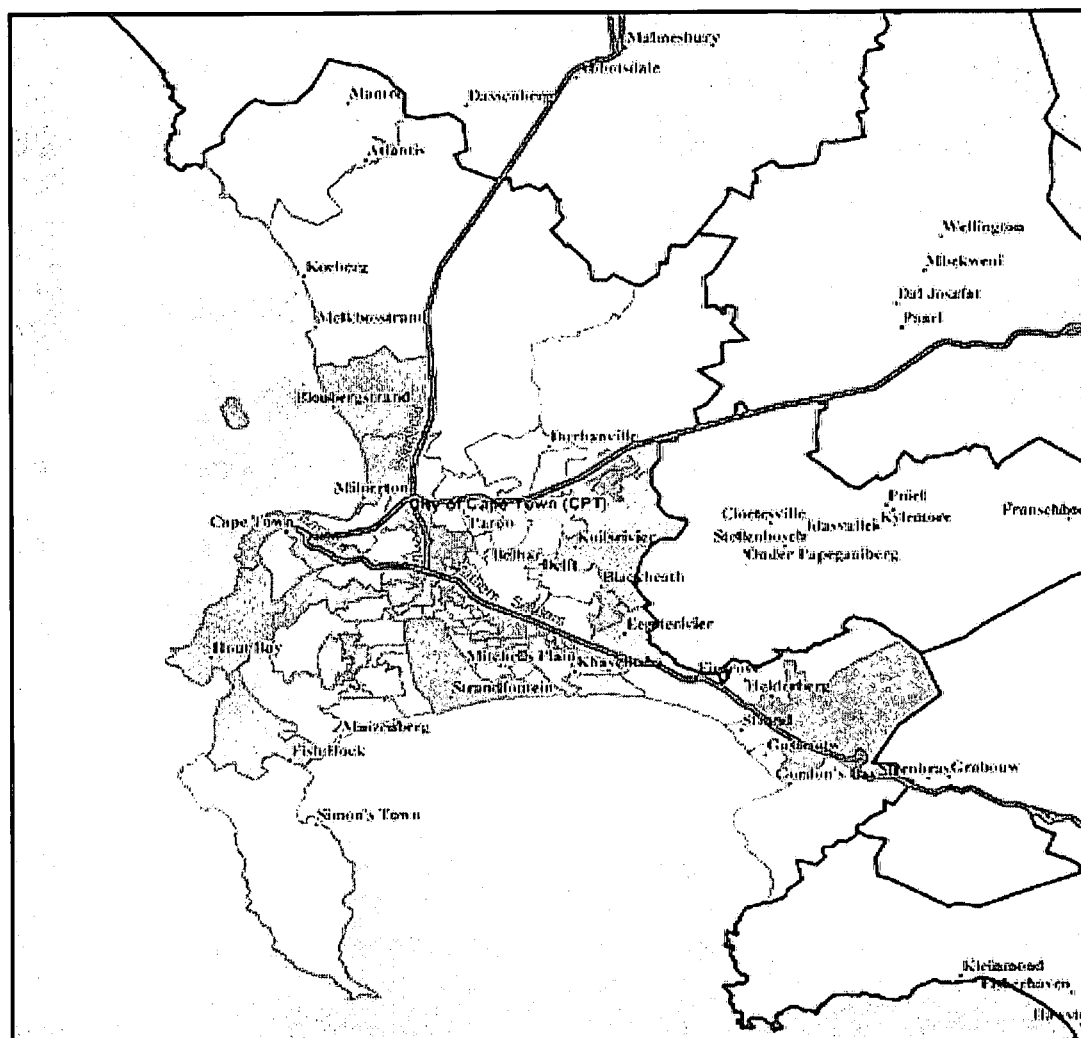
<sup>17</sup> Similarly, SA Statistics 2002 gives the Western Cape a HDI calculation of 0.762.

<sup>18</sup> Source: Human Development Report. In: South Africa at a Glance, 2003-4, Editor's Inc.

<sup>19</sup> The 2001 population statistics are contrary to the 1996 Census statistics indicating an estimated population of 3 956 875 million, thus, indicating population growth from 1996 to 2001.

<sup>20</sup> Source: Census 2001.

Figure 3.2 The Cape Town Unicity district



Source: <http://www.demarcation.org.za> [2005: November]

The languages spoken most are sequentially Afrikaans, Xhosa and English, which are also the main official languages in the Western Cape language policy<sup>21</sup> (see Table 3.1). The Western Cape Cabinet approved the language policy of the Western Cape in principle on the 21 November 2001 (Western Cape Language Committee Annual Report, 2001/2002). The objectives of the provincial language policy correspond with the objectives of the national language policy framework.

<sup>21</sup> Source: [www.statssa.gov.za/census2001/digiatlas/stats](http://www.statssa.gov.za/census2001/digiatlas/stats)

**Table 3.1: % Distribution of the Western Cape population by language and race, 2001 (Approximate deductions).**

Language Group	Population (by race) Group %				
	Black African	Coloured	Indian/Asian	White	Total %
Afrikaans	1.21	43.69	0.17	10.20	<b>55.27</b>
English	0.55	10.04	0.78	7.95	<b>19.33</b>
IsiXhosa	23.64	0.07	0.00	0.02	<b>23.74</b>
Other	1.28	0.10	0.04	0.24	<b>1.66</b>
<b>Total %</b>	<b>26.69</b>	<b>53.91</b>	<b>1.00</b>	<b>18.41</b>	<b>100.00</b>

*Source: Statistics South Africa (Census 2001).*

### 3.2.3 The Cape Unicity

#### 3.2.3.1 The changing context

The Cape Unicity is a highly urbanised area with a high population density in most areas (see figure 3.2). The estimated population in 2003 for the Cape Unicity is approximately 3 393 573 million<sup>22</sup> people of, which indicates that 90.4% of the population are living in urban areas (Bekker, 2001; Du Toit, 2001, South Africa at a Glance, 2003-4 & Cape Metropolitan Council Technical Report, 1996). Furthermore, the region is characterised by an intense movement of people, goods and services, business and industrial districts as well as prospects for extensive development<sup>23</sup>. Thus, the Cape Unicity represents the centre for economic activity, which partially explains the rapid urban growth towards the city centre (Cape Metropolitan Council Technical Report, 1996).

The Cape Unicity comprises the Blaauwberg, Cape Town, Helderberg, Oostenberg, South Peninsula and Tygerberg regions (figure 3.3). The region is renowned for its unique historical, cultural and economic features but is consequently challenged by migration<sup>24</sup> and urbanisation, particularly to the inner metropolitan region (1996: 11). Subsequently, most of the economic activity is generated here; the highest population growth is experienced and it hosts the greatest concentration of disadvantaged communities (1996: 10). The Tygerberg, Oostenberg and Central Cape Town areas are particularly rich in

<sup>22</sup> Source: <http://www.capetown.gov.za>

<sup>23</sup> Source: <http://www.capegateway.gov.za>

<sup>24</sup> The Western Cape is generally a net receiving province where an estimated 48 000 people migrate to the province annually (Bekker, 2002: 75).

residential, commercial, recreational and employment opportunities including the best functional areas for accessing [health] facilities and services (1996: 17). Hence, the best functioning areas appear to be the Tygerberg and Southern Arm districts (1996: 17).

The above-mentioned characteristics consequently serve as pull factors in the increasing [step – wise] migration flow of Africans from bordering provinces or former ‘homelands’ to the Cape in search for employment and provision (Bekker, 2001 & 2002 & South Africa at a Glance, 2003 – 4). Another contributing factor to the increased migration of Africans, particularly working class and poor Xhosa-speakers are the abolishment of the Apartheid laws. These laws comprised the Group Areas Act (1950), the Coloured Labour Preference Act (1954); Pass Laws and the Native Laws Amendment Act of 1923 and 1952<sup>25</sup>; which were “mechanisms of influx control” into urban areas (Johnson, 1994: 78).

Since 1994, South Africa’s general policy regarding urbanisation has been 1) the promotion of maintaining a free enterprise system on the economic markets, (2) a commitment to democratic privileges regarding equal treatment/opportunities for all and rejecting discrimination and; (3) to respect human dignity, life, liberty and property [Carlsnaes & Muller, 1997]. At the same time, the impact of globalisation has resulted in the rapid transfer of technological developments, knowledge, goods and services, particularly knowledge and expertise from foreigners<sup>26</sup> (Nyamnjoh, 2003; & Carlsnaes & Muller, 1997). Consequently, due to the above pull factors there has also been an increase in foreign migrants, specifically foreign Africans, who are mainly ‘illegal’ immigrants<sup>27</sup> and/or refugees (Carlsnaes & Muller, 1997: 235; & Cape Metropolitan Council Technical Report, 1996), putting pressure on the social services sector such as health care and housing, and social infrastructure such

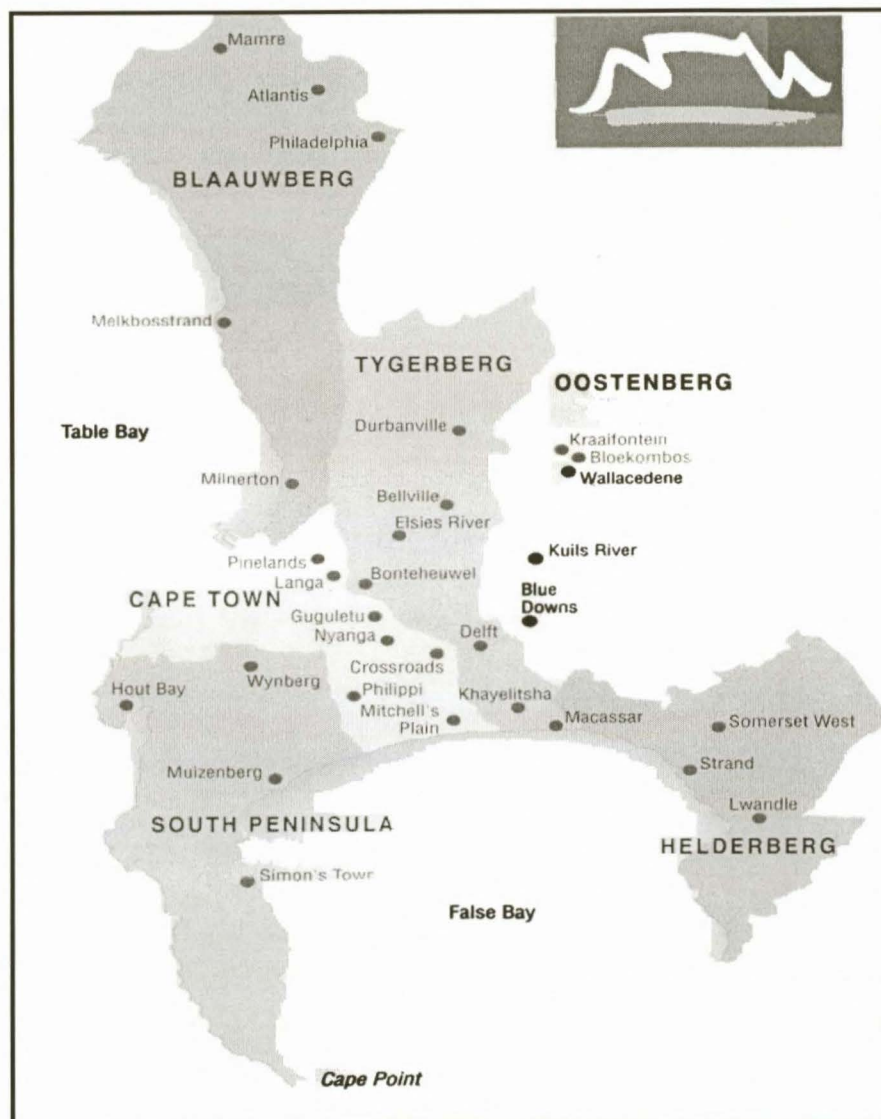
<sup>25</sup> See Bickford – Smith, van Heyningen & Worden, 1999: 124).

<sup>26</sup> In 1998, the number of foreign doctors working in the public health sector was estimated to be 4.4% in the Western Cape. Source: Health Systems Trust. In: South African Institute of Race Relations Survey, 1999/2000.

<sup>27</sup> Carlsnaes & Muller (1997) argue there are approximately eight million illegal immigrants in South Africa (233). They do not indicate whether most of these illegal immigrants are ‘African’. Statistics South Africa (2001) estimated that 27.2% of the total number of immigrants were from Africa and the number of illegal immigrants was estimated between 500 000 and 4.1 million.

as transport and roads (Cape Metropolitan Council Technical Report, 1996; & Carlsnaes & Muller, 1997). Simultaneously, push factors include inefficient transport and health services from poverty-stricken areas of the Eastern Cape (Bekker, 2001) as well as destabilising conditions for foreign Africans in their home countries (Carlsnaes & Muller, 1997).

**Figure 3.3: The six regions of the Cape Unicity**



*Source: Bickford – Smith, et al., 1999*

Urban growth also creates opportunities for the essential development and upgrading of the Cape Unicity's infrastructure and the delivery of social services (1996: 14, 15).

### 3.2.3.2 Language distribution

The Cape Unicity is a linguistically diverse region (see table 3.2). In this area, the most prevalent home languages are Afrikaans, Xhosa and English in ranking order.

<i>Home language</i>	<i>Persons</i>
<i>Afrikaans</i>	41.4
<i>English</i>	27.9
<i>IsiNdebele</i>	0.06
<i>IsiXhosa</i>	28.7
<i>IsiZulu</i>	0.25
<i>Sepedi</i>	0.05
<i>Sesotho</i>	0.66
<i>Setswana</i>	0.14
<i>SiSwati</i>	0.04
<i>Tshivenda</i>	0.03
<i>Xitsonga</i>	0.05
<i>Other</i>	0.56

Source: <http://www.statssa.gov.za/census2001>

**Table 3.2: Percentage (%) of persons speaking home languages in the Cape Unicity, 2001.**

The three dominant languages are geographically spread across selected Cape Unicity sub regions (figure 3.4). Afrikaans language speakers are situated predominantly in the Blaauwberg, Tygerberg, Oostenberg and Helderberg sub regions. English language speakers appear to predominate the South Peninsula and Cape Town Central areas. The presence of 'multiple' (more than one or two languages) or 'other' languages are widespread in small percentages across the Cape Metro. The chief area where Xhosa predominates is in Khayelitsha and the broader Cape Flats. A significant Xhosa-speaking population is also situated on the eastern border of the Helderberg area.

## 3.3 Public Health Sector

### 3.3.1 South African context

Historically, the public health policies during the colonial and Apartheid era played a major role in the exclusion of the indigenous groups, who were viewed as the source of infectious diseases, from the white population (Popenoe, Cunningham & Boulton, 1998: 231). Subsequently, health services were highly fragmented along ethnic lines resulting in 18 different health departments



(Popenoe, et al., 1998). The provision of resources and services to the health departments for each of the so-called Homelands was also distorted. In Transkei and Ciskei, for example, the majority of mainly white doctors refused to admit African patients to their waiting rooms and allowed them to sit and wait for a doctor seen fit to treat them (Johnson, 1994: 100).

The allocation of services and resources was mainly geared to the private sector and urban areas, which contained the bulk of [mainly white] health professionals in the country (Popenoe, et al., 1998). This reflected vast social, linguistic and communication barriers throughout the public health system. However, following South Africa's democratic transition there are huge challenges to transform public health and other government services by, inter alia, promoting of national unity among divided social groups.

The national health sector comprises two main sectors, which are public and private. The public health is owned or funded by the state and is mainly used by state patients. State patients are mainly the unemployed from poor and lower income groups who do not have access to medical aids. Private patients belong to medical aids and mainly use the services of the private health sector. There are a few private patients who do make use of state health services. The private health sector is owned and funded by private donors comprising the mainly economic elite (Foster, Freeman & Pillay, 1997).

There are four factors to take into consideration regarding the general health context. Firstly, there are significantly more private than public health facilities in all of the other seven provinces, except for the Gauteng and Western Cape (Du Toit, 2001: 11). Secondly, in each of the four years during 1995 to 1998, 'public health facilities were the most frequently used in South Africa and there was a gradual decrease in the use of private facilities in each year' (Hirschowitz, Sekwati & Budlender, 2001: 5). Accordingly, the most consultations were in public hospitals and clinics and a very small proportion of people consulted traditional healers beforehand (Hirschowitz, et al., 2001). Thirdly, the state health sector has many dimensions in terms of locality and specialization (V. de Vries, personal communication, Dec 4, 2003).

In terms of specialization, the state health facilities consist of primary care, centralised/tertiary and district hospitals<sup>28</sup>. Larger specialized and training units characterise tertiary state hospitals for professional stakeholders such as nurses, doctors, specialists and therapists. [Professional health stakeholders are those who render services such as nurses, various doctors, hospital management and administration, and associated health workers such as psychologists and social workers (Joseph, 1994; Hershey, C. 1973; & Hasenfeld, Y. 1983).

Patients are also regarded as stakeholders in health services as they are consumers of health care delivery (Joseph, 1994)]. Conversely, district state hospitals are smaller units, and comprise primary health care and include the treatment of serious health conditions. Primary Health Care facilities comprise various clinics and day hospitals where basic services such as first – entry observations, consultations and medication are offered. In terms of locality, state hospitals are positioned in rural and urban areas, and also fall in the three spheres of government, local, provincial and national.

Public health facilities are then subdivided so that a large proportion of primary health care facilities fall under the jurisdiction of local government, the municipality. It is only Community Health Centres (CHCs) among others, together with secondary and tertiary sector facilities that fall under the jurisdiction of provincial government (V. de Vries, personal communication, Dec 4, 2003). Tertiary sector facilities are not only a matter of both local and mainly provincial concern, but are also a matter of national priority.<sup>29</sup> This means that tertiary level health facilities represent all three spheres of government comprising local, provincial and national government.

Finally, 'health care resources in the country are under enormous pressure, although health expenditure in the provinces is nearly 25% of their total expenditure' (Du Toit, 2001: 10). Since 1998, public health services have

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<sup>28</sup> See Ch.4, section 4.3.1.

<sup>29</sup> Department of Health (1997). White Paper on the Transformation of the Health System in South Africa. *Government Gazette No. 17910*. Pretoria.



presumably been in a crisis where significant staff shortage, collapse of services, shortage of qualified staff and budget constraints among others were experienced (Forgey, Jeffery, Sidiropoulos, et al.; 1999: 232; 233). Moreover, doctors argued “primary health care clinics were not operated by qualified staff and thus patients ‘streamed’ to the tertiary [health] institutions” (1999: 232).

The current effects of globalisation and urbanisation have consequently changed the social demographics of the overall provincial population. For instance, in language use<sup>30</sup> isiXhosa has replaced English as the second most spoken language in the province. However, English has also been perceived as hegemonic in status to indigenous and other minority languages such as isiXhosa and Afrikaans (Finchileschu & Gugu, 1998; Madiba, 1999; Mutasa, 1999; Bekker, 1999; Parry, 1999; Maurais & Morris, 2003; & Ntswera, 2005). The consequences might be a language barrier or gap, which could influence patients’ health status and have a negative impact on health care provision or service delivery (Dressler, 1996; Rueda – Lara, Buchert, Skotzko & Clemow, 2003; Baldwin, 2003; Bowen, 2003; Watts, 2003; Iezzoni, O’ Day, Killeen, et al., 2004; Holtzhausen, 2004; Garroute, Kunovich, Jacobsen, et al., 2004 & Rees Jones, Berney, Kelly, et al., 2004).

### **3.3.2 The Cape Unicity and the Western Cape**

The Western Cape Department of Health ‘is one of the largest departments in the province and aims to offer patients appropriate and affordable health care services (Western Cape Provincial Department of Health, 2005). The majority of patients making use of public health services (V. de Vries, personal communication, Nov 27, 2003) do not belong to medical aids. According to the Provincial Health Department, many of these people are from the Cape Unicity.

There are an estimated twelve million visits to Primary Health Care (PHC) facilities in the province annually and 2.5 million in – patients daily in hospitals<sup>31</sup>. Furthermore, the province boasts a ratio<sup>32</sup> of medical personnel per

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<sup>30</sup> See Census 1996 and 2001. Statistics South Africa.

<sup>31</sup> <http://www.capegateway.gov.za>

<sup>32</sup> Source: Health Systems Trust, 1998. In: South Africa Survey 1999/2000. South African Institute of Race Relations.

10 000 of the population, which is the second highest (98.6) in the country, after Gauteng. Health care services are provided in various facilities in four regions of the province. There are currently 197 public health facilities situated in the Cape Unicity: there are 3 central hospitals, 88 clinics, 43 community health centres, 3 district hospitals and 5 regional hospitals.

The Cape Unicity's local health region is currently divided into ten sub districts (figure 3.5), which are aligned to the sub regions of the Cape Unicity<sup>33</sup>. Of all the health districts mentioned, the Khayelitsha health district is the most densely populated with approximately 407 050 people clustered in a single space<sup>34</sup>.

Similarly, the province's public health sector has become burdened by the impact of urbanisation, globalisation and migration, even though health expenditure is approximately at 27% (Du Toit, 2001: 10; Bosman, 2004 & Dreyer & Smetherham, 2003). A previous study indicated that migrants outside the province perceived 'health services in the Western Cape to be one of the best in the country' (Bekker, 2002: 31). In practice, the Department of Health and hospital management have acknowledged the growth of Xhosa-speaking patients, mainly from the Eastern Cape, in the hospital (personal communication, 27 Nov, 2003).

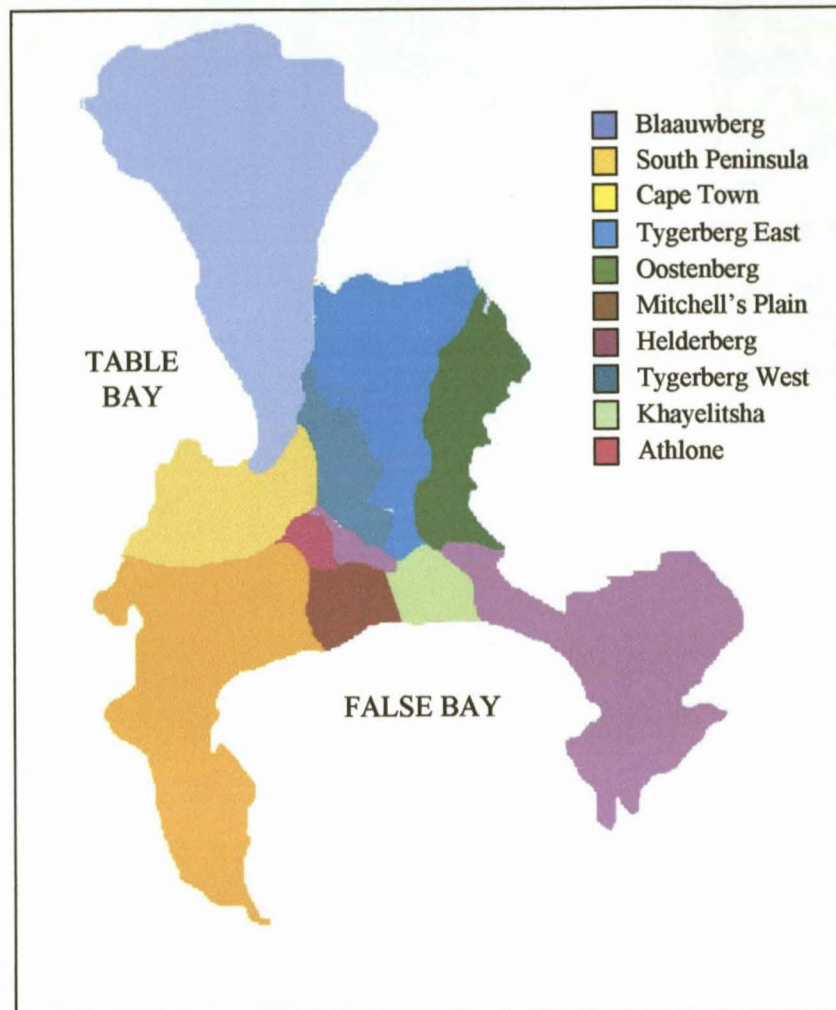
### **3.3.3 Health policy and the Patients' Rights Charter**

Based on the national Healthcare Plan for 2010, the Provincial Health Department ought to recognise the need to maintain and improve [equal] access by providing interpreting services between medical personnel and patients/clients (De Vries, 2003).

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<sup>33</sup> See figure 3.3.

<sup>34</sup> A rough estimation for Khayelitsha and surrounds is 4 691- 20 391 persons per square km. Source: <http://www.statssa.gov.za>. Also, see <http://www.capetown.gov.za/health> for further statistics for each health district.

**Figure 3.5: The ten health districts of the Cape Unicity**

[www.capegateway.gov.za](http://www.capegateway.gov.za)

Accordingly, the implementation plan<sup>35</sup> for the Western Cape Language Policy has outlined the following implications for health services:

- Overall, a ten-year medical interpreting programme, which aims to provide quality medical interpreting services in health. The programme will include:
  - The appointment of 36 medical interpreters per year over a ten-year period.

<sup>35</sup> Source: Emzantsi Associates 2003. 'Costing the Draft Western Cape Language Policy'. Western Cape Language Committee and the Department of Cultural Affairs and Sport. In: De Vries. 2003. The Draft Western Cape Language Policy and its implications for Health Western Cape. 2003. Western Cape Provincial Department of Health.

- An outsourced programme of training 36 new community interpreters a year over ten years to support medical interpreters, mainly in the clinics.
  - A new course in multilingual communications for health professionals, who ought to be trained in socio – cultural and language awareness, over ten years.
  - A training programme for medical interpreters in cultural awareness, medical interpreting and terminology as they are recruited.
  - The recruitment of isiXhosa staff for emergency services, which ought to meet the target of 20% Xhosa-speaking emergency service staff.
  - A pilot telephone interpreting programme for hospitals and clinics to improve access for Xhosa-speaking and Sign language patients.
- Similarly, District Health Services, Central Hospital Services and Provincial Hospital Service programmes shall be equipped to provide personnel training in cultural awareness and health promotion in all three official languages (Afrikaans, English and isiXhosa); interpreting between personnel and patients; ensuring that information is available in all three official languages and increasing the number of multilingual staff (Emzantsi Associates, 2003).

Subsequently the implementation plan of the Language Policy regarding health is a necessary requirement so that the Batho Pele principles and the Patients' Rights Charter are realised in practice (De Vries, 2003). The Charter briefly entails the following:

- Every patient has the right to a healthy and safe environment that will ensure his or her physical and mental well – being. The patient's right must be protected from all forms of environmental danger such as pollution or infection. Patients are also obligated to take care of the environment and their own health.

- Every patient has the right to participate in the development of health policies as well as decision – making on matters affecting his/her health. Moreover, the patient is obligated to be knowledgeable about his or her local health services and what they offer and to enquire about the cost of treatment and/ or rehabilitation procedures.
- Every person has the right of access to health care services, specifically treatment and rehabilitation that must be made known and understood by the patient. The patient also has the right to be informed about the availability of health services, know how to use such services and receive information in the language that is best understood by the patient. The patient must provide health personnel with relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes.
- The information provided by the patient should be treated confidentially. The information given may only be disclosed by informed consent, except when required in a court of law.
- A person has the right to refuse treatment, which must be done verbally or in writing, provided that the refusal consequently does not endanger the health of others. The patient may also be referred for a second opinion on request to a health provider of his or her own choice. The patient may not be abandoned by a health care professional or provider who is responsible for the patient's health.
- The patient has the right, inter alia, to lodge a complaint concerning health care services and that such complaints should be investigated in order to receive a full response.

### **3.3.4 The referral system in the health districts**

According to the Primary Health Care (PHC) framework, the referral system is the means to ensure the most cost-effective use of resources and the highest possible quality of service and health care (Le Roux, personal communication, July 2004). This means that a patient can be treated at the most appropriate level nearest to their home. The referral system is based on three levels of health care, namely primary, secondary and tertiary care.

The referral system operates at the patient's first point of contact, which is at a [mobile] clinic, community health centre (CHC) or day hospital situated nearest to the patient's home or municipal region. This is known as the *primary level* of undergoing medical treatment. Subsequently, the primary level is regarded as the most important stage since 90% of the cases that enter this phase are anticipated to be treated or cured. More specifically, community health centres are considered the backbone of the primary level of health care and many of these facilities provide a twenty -four-hour service.

Many patients are informed to enter the health system at this level that operates spatially in different suburbs or health districts. If the patient's condition is complicated or cannot be effectively treated at primary level, then he or she is referred to a district or regional health facility such as a general hospital. Examples of such hospitals are Karl Bremer, Somerset and Victoria. This might include the availability of general specialised services such as surgery, gynaecology and paediatrics. These hospitals also provide primary level health care. This is known as the *secondary level* of health care. State patients are only referred to regional or district facilities if their health condition is complicated or rather serious.

Serious health conditions vary in terms of less serious, more serious to urgent. The patient is then referred to the health facility that is within or nearest to their municipal and/or provincial region. If the patient's condition is more serious to urgent and requires specialised care, he or she should then undergo further observation and the patient will be referred to a *tertiary level* medical facility. This comprises academic and centralised hospital units where medical care is scientifically developed, researched and trained to health professionals involved in health care. Examples of such health facilities are Groote Schuur Hospital, Tygerberg Hospital and Red Cross Children's Hospital. These tertiary level facilities not only cater for patients inside municipal (local) and provincial government spheres, but also at national and even international levels. Theoretically, only a small number of patients are referred to secondary and tertiary level care. It is only the primary level that can refer patients with



complications and patients who have been treated unsuccessfully, by means of a written referral letter or by telephone.

### **3.6 Conclusion**

The chapter highlights three historical and current contexts, namely the South African, Western Cape and Cape Unicity contexts. Two main themes are discussed against this background, namely language (specifically in terms of distribution and policy) and public health. This is presented in sections 3.2 and 3.3. In section 3.2.1 and particularly 3.2.1.1, the focus is on the historical context of language(s) in the South African context. Then attention is paid to the contemporary post-1994 democratic period in subsection 3.2.1.2. Here South Africa is posed as a diverse nation comprising eleven official languages in terms of the Constitution of the Republic of South Africa and the National Language Policy framework [subsection 3.2.1.3], endeavouring to redress the social inequalities of the past and foster national unity.

The focus then shifts to the Western Cape [subsection 3.2.2]. The Cape Unicity [subsection 3.2.3] is discussed where urbanisation [3.2.3.1] and consequently, the changing language demography [subsection 3.2.3.2], inter alia, impact on social service delivery. Similarly, the public health sector is discussed in section 3.3. This is discussed in subsections 3.3.1 and 3.3.2. The health policy and the Patients' Rights Charter relating to language issues are discussed in subsection 3.3.3. Subsequently medical interpreting is introduced with emphasis on Xhosa and Sign Language interpreters. Lastly, the operation of the referral system in the health districts is briefly discussed in subsection 3.3.4.

## **CHAPTER FOUR: METHODOLOGY AND DESIGN OF THE STUDY**

### **4.1 Introduction**

The chapter addresses the choice of methodology and design for this study. The type of research design is identified and briefly discussed. The most suitable research approach for the study is required in order to collect sufficient data, to conduct the analysis, making proper judgements on the methodology and the possibility for replication studies (Babbie & Mouton, 2001: 282). This is done in section 4.2. The unit(s) of analysis are discussed, namely the Cape Unicity's public health sector. These include a brief description of each of the five selected health facilities, which are identified in subsection 4.3.1. The selection of respondents is discussed along with the data collection procedures. This is done in section 4.3.2. The use of methodology and techniques is also highlighted. There are certain factors that cause difficulties when doing research, particularly in the fieldwork environment. These factors tend to threaten the validity or reliability of the study consequently influencing the interpretation of the research results. A more detailed discussion of these shortcomings is presented in section 4.4.

### **4.2 Qualitative study**

The study empirically explores language diversity in policy and practice in the Cape Unicity State Hospitals. The study is exploratory for three reasons:

- a new field where no or little research has been undertaken is explored;
- extensive information concerning the relationship between language(s) and society particularly in the health sector, where such information is limited is gathered, and
- as much information is gathered and experience gained to develop an understanding of the research process in order to assess and provide explanations or recommendations in future.

The study is characterised as "largely qualitative in nature, aiming to provide in-depth descriptions and understanding of a group of people or community. Such descriptions are embedded in the life-worlds of the people or setting under observation. Furthermore, qualitative research designs aim to produce insider



perspectives of the research setting and their practices” (Mouton, 2001: 148). Accordingly, the methodological strategy considered appropriate for the study is therefore qualitative.

Qualitative methodology is the ‘methodology of choice when exploring a situation in which one seeks to learn about issues that are most relevant to the experiences of the participants’ (Duggan, 2000). Similarly, the symbolic interactionism (phenomenological) perspective, ‘encourages the researcher to get as close as possible to the subject(s) observed’. Hence, the outsider is able to understand the meanings they attach to their actions and interactions with other people’ (Babbie & Mouton, 2001: 32). The underlying commitment is to ‘get close, be factual, descriptive and quote...about the respondent(s), but also to maintain objectivity at the same time (Seidman, 1998; Layder, 1994). Stated differently, the researcher is committed to represent participants in their own terms and to give a living sense of day-to-day talk, activities, concerns and problems. Hence, the audience is able to project themselves into the point of view of the people presented’ (Ferreira, 1982: 205). In the process of data interpretation and analysis, qualitative methodology is reflexive and recursive, continually returning the words of the participant to guide a successive enquiry’... (Duggan, 2000: 25, 26). In general, ‘qualitative methodology allows the intensive study of a small number of participants and capable of conveying substantial depth of analysis’ (Duggan, 2000). However, qualitative research is rather unpredictable and flexible in its methodology, thus the research design is likely to change in the research process (Babbie & Mouton, 2001).

## **4.3 The selection of cases**

### **4.3.1 Selection of institutionalised cases**

The selection criteria of health facilities was based on i) the operation of the referral system; ii) the spatial distribution of the settings and; iii) emphasis on the three tertiary health facilities. One Community Health Centre is selected, one secondary hospital, and three tertiary facilities each of which caters for local, provincial and national services concurrently. Three tertiary institutions are selected since it was hypothesized that patients at these facilities would be drawn from diverse language backgrounds.

These health facilities are selected moreover since they spatially represent the Cape Unicity in terms of the highly urbanised districts they are situated in. Those local or health districts reflect the language distribution of the three main languages of the provinces. These districts are also mainly based where accessibility and economic opportunities are highly probable (Cape Town Municipal Technical Report, 1996).

The five health facilities are briefly introduced:<sup>36</sup>

- **The Khayelitsha Site B Community Health Centre (CHC).** This is the only primary level facility offering twenty – four hours service and after hours emergencies in the Khayelitsha health district. It is situated in the Site B section of the suburb, which is constantly busy and surrounded by shopping outlets, service centres and nearby bus routes. The clinic's services include daily treatment for adult acute and chronic illnesses as well as adult and child emergencies. It is therefore the recommended unit as it is the safest and most popular health facility for research in the suburb (Bitalo. L, personal communication, 2004).
- **The Hottentots Holland Hospital** situated in Somerset West, in the Helderberg health and local district is a secondary level facility in the Helderberg region of the City of Cape Town. The hospital also offers general specialised services to patients in the province.
- **Tygerberg Academic Hospital**, situated in the Parow area of the Tygerberg region. This tertiary level hospital consists of multi-disciplinary units and medical specialists. It was built around 1963 and officially opened in 1976, for the purpose of accommodating a growing demand for the training of medical staff (M. Carstens, personal communication, June 2004). It is also the first institution (linked to Stellenbosch University) to teach medicine and dentistry in Afrikaans (Bickford-Smith, et al., 1999: 186). It currently offers twenty-three specialised services, including the Carel du Toit Centre that is also investigated. The Centre is a school for deaf, marginalised children who

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<sup>36</sup> The following information was retrieved from the Cape Town Unicity Council during March 2004.

are educated in their mother tongue (Ruth, personal communication, July 2004).

- Similarly, **Groote Schuur Hospital** is linked to the University of Cape Town and situated in a mainly English-speaking district of the Southern Arm of central Cape Town. It remains a historical site where the world's first heart transplant was successfully conducted in 1967 (Bickford-Smith, et al., 1999). It is also regarded as the key health service facility for international research and academic or specialised training in the Cape Unicity<sup>37</sup>. The total number of staff is estimated to be around 3 663.
- The **Red Cross Children's War Memorial Hospital** came into existence around 1944 when there was an outbreak of polio and tuberculosis during the war period, particularly among black children (Bickford-Smith, et al., 1999). This then led to a growing demand for a children's hospital. In 1956, the hospital was officially opened in memory of soldiers who died in Word War Two. This facility is located in the Rondebosch area, which borders the Cape Town Central/Southern Suburbs health and local districts. It is the main academic hospital for children in South Africa and the continent of Africa Moreover, the hospital has academic links to the University of Stellenbosch, University of Cape Town and the University of the Western Cape's Faculty of Dentistry. The total number of staff is approximately 1 100, varying from academics, doctors, nurses, professionals in applied medicine and clerical and non-professional staff.<sup>38</sup>

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<sup>37</sup> Source: [www.capegateway.gov.za](http://www.capegateway.gov.za)

<sup>38</sup> Source: [www.capegateway.gov.za](http://www.capegateway.gov.za)

**Table 4.3: The selection of institutionalised cases**

Selected health facility	Local district	Health district	Referral level	Language use	
Site B CHC	Tygerberg; Khayelitsha		Primary	<b>Staff</b> – Mainly Xhosa among African staff & English among minority non-African staff.	<b>Patients</b> overwhelmingly Xhosa-speaking and minority of English, Afrikaans and other foreign African and indigenous South African languages.
Hottentots Holland Hospital	Helderberg		Secondary	<b>Staff</b> – Mainly Afrikaans & little English among staff. African languages are also evident among African staff.	<b>Patients</b> Mainly Afrikaans and little English. Also some African languages among African patients.
Tygerberg Hospital	Tygerberg; East and West Tygerberg		Tertiary	<b>Staff</b> – Mainly Afrikaans, some English, small proportion of African language(s) amongst African staff only.	<b>Patients</b> In ranking order, Afrikaans, English and then isiXhosa growing strongly.
Groote Schuur Hospital	City of Cape Town; Cape Town Central		Tertiary	<b>Staff</b> – Shared dominance – English & Afrikaans & little African languages.	<b>Patients</b> Shared dominance – Afrikaans and English. Also a significant number of African/other languages spoken.
Red Cross Children's Hospital	City of Cape Town; Cape Town Central		Tertiary	<b>Staff</b> – Shared dominance – English & Afrikaans, little African/other languages	<b>Patients</b> Very diverse as English, Afrikaans and isiXhosa are used for communication.

### 4.3.2 Selection of interviewees

The study is based on field studies in state hospitals in the Cape Unicity area. The initial plan was to select five respondents comprising one doctor, one nurse, one administrator or manager, one patient and a trained interpreter. A trained interpreter is regarded as someone specially trained to interpret medical terminology from one language to another. In this case, specially trained medical interpreters would be required to interpret from English to isiXhosa and back. Patients selected were drawn solely from the Xhosa-speaking population.

There are two reasons why the focus was on Xhosa speaking patients. Firstly, the language policy of the Western Cape and Cape Unicity states there are three official languages: Afrikaans, isiXhosa and English. Secondly, this is contrary to the former language policy, which excluded isiXhosa and other indigenous languages, resulting in the discrimination against Xhosa speakers.

This was to be done for each selected health facility, which would then total twenty-five respondents. Each person would be randomly systematically selected where every third person would be selected (Babbie & Mouton, 2001). Accordingly, every third person, wardroom or every third person in the room was to be preselected. In order to do this, a staff register would have to be obtained to select health professionals and patients would be chosen from outpatient waiting areas or wards.

Triangulation strategies would be used to obtain valuable data because they 'increase the researcher's confidence in his or her research results (Ferreira, 1984). This involves using a combination of data collection techniques such as participant observation, natural observations, semi-structured (individual), interviewing, unstructured face-to-face conversations and other existing documentary sources. This is being done in order to avoid narrow context effects and respondent/researcher bias, which might interfere with the study (Bernard, 1995). Where possible, volunteers and support staff were an alternative option in order to gain understanding and be comfortable with the setting.

The interview guides were piloted at an alternative clinic two weeks prior to the official field period. The fieldwork period was anticipated to be completed within one month with a maximum of one week at every facility.

Due to contextual constraints, the initial plan did not realise. Considering the difficulty of gaining access, I could only be accommodated within a specific period, which limited my opportunity to pilot my interview guides independently. Moreover, random systematic sampling was abandoned in favour of 'convenience sampling' (whoever is available and willing to participate) and

snowball sampling (referrals and recommending the next appropriate person) [Babbie & Mouton, 2001; Bernard, 2002]. I could not obtain access to the staff register due to the unpredictable nature of the settings, which was characterised by staff shortages, staff presence and the code of conduct of certain facilities<sup>39</sup>. The use of non-probability sampling methods was more appropriate for the nature of the setting (Babbie & Mouton, 2001). In other words, staff colleagues and staff who were interviewed would recommend or refer to the next potential respondents.

The formality of gaining access to certain facilities as well as the lack of staff attendance also contributed to the refusals recorded and the extension of the fieldwork period from one to six months. The access to the first facility afforded me the opportunity to pilot the interviews in preparation for the forthcoming facilities. This could be done since a degree of flexibility is encouraged in qualitative research (Babbie & Mouton, 2001).

The **data collection** process started at Red Cross Children's hospital and ended at Groote Schuur hospital from June to October 2004. Certain levels of management, supervisors and directors of the health settings were approached beforehand and were informed of the study. Follow-ups with the respondents and re-observations were also conducted during and after the fieldwork period. The respondents were selected from each setting until the target of five respondents from each setting was selected (see table 4.4). Twenty-five interviews were recorded of which six were translated from Xhosa to English and nineteen conducted in English and Afrikaans. Only six refusals were recorded.

The construction of the interview guides was based on two related studies on language policy and views on languages in practice (see Finchileschu & Gugu, 1998; & Alexander, N, Hattingh, B., Mkhulisi, N. & L Nyangintsimbi, 2001). The questionnaires were successfully piloted and implemented in a similar study. Consequently two interview guides were constructed; the first one<sup>40</sup> for respondents in administration or on the behalf of hospital/clinical management

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<sup>39</sup> I was not allowed access to the staff register, as this was considered confidential.

<sup>40</sup> Interview guide paper one (see appendix).

whose work is concerned mostly with written and internal communication (policy documents and letters) circulated to clients and office staff, and the second one<sup>41</sup> for respondents engaged in the everyday practice of health care provision such as the doctors, nurses, patients, and where possible, official interpreters. If no official interpreter was available, a doctor or preferably a nurse or patient would be substituted.

**Table 4.4: Interviews carried out with total number of respondents at each facility**

Cases <i>n</i> =	Patient	Doctor	Nurse	Administration	Official Interpreter
Khayelitsha CHC (Site B)	2	1	1	1	0
HHH	1	1	2	1	0
RCH	NA	1	1	1	2
TBH	1	1	1	1	1
GSH	1	1	2	1	0
Total <i>n</i> =25	5	5	7	5	3

The interview guides were then used as an opportunity to pilot and where possible make the necessary changes to the guides. Accordingly, unstructured and semi-structured interviews were conducted with respondents by voluntary participation and verbal consent. Moreover, casual conversations and obtaining secondary data such as information pamphlets, letters from the public concerning each setting were additionally collected. The interviews were conducted at appointed times most suitable to the respondent. The interviews lasted approximately thirty minutes to one and a half hours, and took place in doctors' consultation rooms, offices and wards that were available. The time spent at each health facility was approximately one week. The interviews were

<sup>41</sup> Interview guide paper two (see appendix).

conducted in all three languages and predominantly in the language of choice of the respondent, especially Xhosa-speaking patients. For this purpose, a Xhosa-speaking assistant, who conducted and translated the interviews in isiXhosa and English, accompanied me.

The respondents were informed before and after the interviews about the nature of the study and were encouraged to ask questions about the study. The respondents were asked open-ended questions concerning their attitudes and understanding of the language policy, policy implications, their views on different languages and their personal experiences with multilingualism in communication with health professionals and patients, among others. Respondents were also asked to give information regarding their gender status, language preference, age, religious affiliation, education, work and employment status, including marital and health status. Consequently, previous research has indicated that these factors influence language practice in the environment (Bettencourt & Molix, 2003; Cheng, 2000; Kamwangamalu, 2001).

For ethical purposes, confidentiality and anonymity, sensitivity to probing and peer reviewing when interviewing respondents were taken into consideration. The interviews were tape-recorded and field notes were made during the interviews, as well as for observations. The observations were recorded at outpatient waiting areas of the clinic, wards and during doctor and/or nurse and patient consultations at the clinics that included spending time with an official interpreter, which was roughly 2 to 3 hours in the morning and mid-afternoon, where possible. Subsequently the data were transcribed, proofread, and coded by a combination of the OCM (Outline of Cultural Materials) method and mnemonic coding. This entailed adding a particular number (e.g. interview no. 0001) for recorded interviews as well as topical codes (e.g. inserting DIV for DIVORCE, etc). This use of coding made the sorting of the data more efficient.

The purpose of encoding data in the data capturing was to ensure the confidentiality and anonymity of participants. Bernard (1995: 192) argues "you just never know what would embarrass or hurt someone if your data fell into the wrong hands". In keeping with ethical standards, the child patients were not



interviewed and therefore replaced with an available nurse or doctor. Furthermore, children are not competent or knowledgeable to provide information about language policy issues (Babbie & Mouton, 2001: 236).

#### **4.4 Research shortcomings and contextual factors**

In this section, I will attempt to identify negative, as well as positive, dimensions of the research.

Firstly access to health facilities was very difficult, particularly at Groote Schuur hospital. Frequent letters were written to the University of Cape Town's Research Ethics Board for permission to conduct research. Subsequently I unexpectedly had to wait for three months while I continuously contacted them to obtain approval for my study. When the study was eventually approved, I underwent a number of telephone consultations with the medical superintendent regarding authorization to conduct research at the hospital. I then had to seek the approval of the Head of the Gynaecological/Antenatal Unit of the clinic, which was not an easy process. Permission was eventually granted late in September 2004, after roughly two weeks of waiting.

I had to report to the Sister in Charge or Chief Matron of the Unit. Appointments were made to meet with the Sister in Charge to discuss my methodology and for referral to potential respondents. There were instances when the Sister never arrived for the appointment and I had to return the next day. I was not informed of her absence, although her appointment with me was scheduled on the same day. The above-mentioned factors contributed to high transport costs and other telephone and printing expenses.

Additional costs accrued for translation of the interview guide and assistance with interview transcriptions, which was time consuming and expensive. However, this was to be anticipated from the beginning of the study. A nurse informed me that Thursday afternoons and Wednesday mornings were the busiest times at the clinic and would then be appropriate for me to make observations. There were difficulties to conduct interviews due to staff shortages and overburdened staff. Some staff were not willing to conduct

telephone interviews after hours despite being informed of the nature of the study.

I then proceeded to the maternity unit of the hospital, which was positioned on the West end, facing the new section of Groote Schuur. The Medical Superintendent assisted me in obtaining interviews by referring me to available wards, where medical staff were not so busy and available for interviews. After two refusals, I was able to interview a nurse and a nursing assistant. The nurses were generally suspicious and constantly enquired about the purpose of the study and most thought I was a representative from the Health Department. I was nevertheless, open about my identity as a student researcher and carefully explained the nature and purpose of the study.

The difficulty continued when the Head of the interns refused me permission to interview a doctor. Consequently, the medical superintendent discussed my position at the hospital at a board meeting, after which the Head of the intern doctors finally agreed to allow me to interview a doctor. I was then introduced by a nurse to the first doctor she approached, who agreed to be interviewed.

Similar experiences and difficulties such as staff shortages and overburdened staff were encountered at the other health facilities, which made the selection of respondents very difficult. The, Red Cross Children's Hospital was an exception as some of the interviews were prearranged and I was assisted by the Sister in charge in the Neurology and Stoma clinics. Similarly, at Tygerberg Hospital I worked through the Public Relations Department and the official interpreter/clerk, who assisted me with referrals to respondents.

Gaining access to Khayelitsha Site B clinic and Hottentots Holland Hospital was made possible through the assistance of Mr. De Vries of the Provincial Health Department and Dr. Bitalo, the Regional Director of Metropole District Health Services. At both facilities, it was difficult at times to conduct interviews and observations due to overcrowded outpatient areas. At Khayelitsha Site B clinic, my interpreter found it difficult to interview patients at the outpatients. Patients were not interested in my research and complained and were

frustrated because they were tired of waiting and just wanted to see a doctor. At one stage, the clinic was very overcrowded with only one doctor available. The clinic then requested locums (standby doctors) to be deployed for the clinic's main section. The other sections of the clinic comprised the maternity, and HIV/Tuberculosis section where I was referred to for interviews and observations. Natural observations were also conducted at the main section of the clinic, except the maternity area.

Researchers go into the field setting, which is a rather unpredictable environment. The unpleasant experiences in such an environment might psychologically affect the researcher. Such experiences were also prevalent throughout the fieldwork period. The observations that were conducted in the consultation rooms and casualty wards comprised accounts of the excretion of bodily fluids such as the sight and smelling of blood, vomit and saliva, bedsores, lesions (from HIV) and other festering wounds. Accordingly, a patient diagnosed with tuberculosis also coughed on my interpreter assistant and myself. This resulted in a personal medical examination when I fell ill. The tuberculosis test was negative, but one has to remind oneself to remain calm and focused while viewing such trauma.

## **4.5 Conclusion**

This chapter focuses on the research design and methodology. In section 4.2, the research design is briefly discussed as being an appropriate qualitative approach to the study. Section 4.3 clarifies the selection of cases or unit(s) for observation. This is presented in subsection(s) 4.3.1 and 4.3.2. In subsection 4.3.1, a brief illustration of each of the selected health facilities is presented. Subsection 4.3.2 describes how the respondents were selected and the data collection procedures are also discussed. This section comprises three parts; firstly, the initial plan is outlined; secondly, how things did not go according to plan due to contextual factors; and thirdly, due to these shortcomings the methodology was carried out in a different manner. For a further look at these shortcomings, a personal account of the research difficulties experienced before and during the fieldwork period is provided in section 4.4.

## **CHAPTER FIVE: LANGUAGE POLICY AND PRACTICE – IDENTIFYING THE GAP IN THE CAPE UNICITY'S PUBLIC HEALTH SECTOR**

### **5.1 Introduction**

Each of the five selected health districts has its own policy regarding language use. After identifying this, the chapter uses empirical research results to establish related practices in each facility and how far the results diverge from policy. Each of the health facilities is analysed independently in the following order: Khayelitsha Site B community health centre, Hottentots Holland Hospital, Red Cross Children's Hospital, Tygerberg Academic Hospital and Groote Schuur Hospital. In each case, a summary of the language policy is provided followed by a summary of stakeholders' (for example, doctors, nurses, patients, and so forth) knowledge of, and attitude to the language policy. Subsequently, the language competency of each stakeholder will be determined.

The analysis establishes language use (practice) in each facility. This is done by using three sets of data: firstly, patients' interviews; secondly, interviews with administration or staff management, doctors, nurses and interpreters; and thirdly, the researcher's observation(s) at the facilities. This analysis is supported by relevant quotes. Based on the results of this analysis the gap, referred to in Chapters one and two<sup>42</sup> is identified in each facility.

In conclusion, the results regarding the gap between policy and practice in each of the five health facilities are integrated and a summary of the gap in the Unicity public health sector will be given.

### **5.2 Comparison of policy implications for each health facility**

Each facility had to indicate whether they had a language policy and what it entails. The respondents were either administration officials or part of management. Respondents were asked to indicate whether they knew about the language policy and what their attitudes were in this regard. This included

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<sup>42</sup> See section 2.4, Ch.2.

the views of administrative officers, doctors, nurses, patients and official interpreters, where applicable. The provincial policy was first explained to them before they were asked to elaborate on their attitudes regarding the policy (Babbie & Mouton, 2001: 236, 237).

The provincial Health Department recently adopted the provincial language policy, which entails the following: the recognition, equal use and promotion of the three official languages<sup>43</sup> (Afrikaans, English and isiXhosa) of the province, the recognition of language choice of the patient. These include the use of the three languages in written, translated, edited and spoken forms for internal and external communication (De Vries, 2003). For health administration, the impact involves developing incentives to promote multilingualism amongst the staff. In order to fulfil this, the promotion, training and deployment of official medical interpreters are acknowledged. Additional provisions are the development of a multilingual communications strategy, training and creating opportunities for staff to become culturally sensitive and becoming proficient in all three main languages.

1) Khayelitsha Site B Community Health Centre (CHC)

Hospital management indicated that 'there is no language policy for the facility'.

**Table 5.4: Knowledge and attitude of stakeholders interviewed at Khayelitsha Site B CHC**

<i>Interviewees</i>	<b>Knowledge of policy</b>	<b>Attitude towards policy</b>
<i>Patient(s)</i>  <i>n=2</i>	No knowledge of policy	"Comfortable with policy and believes it can play a big role in health services". Thinks, "policy will succeed due to problems in health, i.e. need for interpreters in consulting rooms". Indicate 'policy should be applied in the province – to feel part of the province'.

<sup>43</sup> The same status is given to Sign, indigenous/heritage and foreign national languages.

<i>Doctor(s)</i> <i>n=1</i>	No knowledge of policy	Think it's important – in order to understand or explain health problems. Policy 'absolutely' plays a role in health evaluation or assessment of patient (through an interpreter). "Most definitely thinks policy will succeed as there is a need for such things, especially where there is a language problem".
<i>Nurse(s)</i> <i>n=1</i>	Yes. Reference is made to establishment of policy.	"Comfortable with policy and believes they (interpreters) will tackle problems facing health. But currently does not see policy working since it has been in place".
<i>Administration/</i> <i>Management</i> <i>n=1</i>	Yes. Reference is made to national policy of 11 official languages.	"Policy is not fully used and implemented – not satisfied with this". 'Don't know, maybe' – concerning policy's success.

Respondents had no or some knowledge of the multilingual policy. The general attitude towards the policy was positive, in terms of its objectives. They were supportive of the policy's role in health services and made reference to the 'use of interpreters' addressing health problems in this regard. There was some division concerning the policy's success, which depended on its implementation particularly in administration and management, and nurses. These stakeholders were sceptical about the policy's success.

## 2) Hottentots Holland Hospital

Hospital management reported that their language policy is based on the language demography of the environment, which is mainly Afrikaans and English. What is used is the language that the patients understand. Management did not respond as to whether they had an official language policy or not.

**Table 5.5: Knowledge and attitude of stakeholders interviewed at Hottentots Holland Hospital**

<i>Interviewees</i>	<b>Knowledge of policy</b>	<b>Attitude towards policy</b>
<i>Patient(s)</i>  <i>n=1</i>	Yes. Reference is made to provincial policy – equal use of 3 languages.	‘Agrees strongly with policy, believes it will succeed and will promote 3 languages equally. Believes establishment of policy can tackle problems facing these sectors’.
<i>Doctor(s)</i>  <i>n=1</i>	No, but vague reference to rights of patient to communicate in his or her language of choice.	Feels that policy is important and necessary, but does not know if it plays a role. Reference to necessity of communicating in 3 languages and in language of patient’s choice.
<i>Nurse(s)</i>  <i>n=2</i>	Yes, reference is made to national policy – ‘11 official languages and can be used as you wish, use the language in which you are comfortable’. Other respondent ‘does not know specifically’, but vague reference to accommodating Xhosa.	Thinks, “policy is fair and...brilliant...It’s vital...we recognise languages. Of course! It plays a role in health – if you don’t have a policy then you don’t have a direction”. Believes policy will succeed (‘it has to in order to work together to provide services’). But ‘we have to get cracking on implementation strategies’.
<i>Administration/</i> <i>Management</i>  <i>n=1</i>	Yes, but vaguely and not in detail. Indicates ‘communicating with patients in their language of choice through an interpreter or ‘maybe someone that can speak his or her language’.	Management does want patient to communicate in his or her language of choice. Believes that policy ‘definitely plays a role in health. Reference to interpreters and influx pressure of Xhosa-speaking migrants. Policy success can only be determined on the basis of employing more Xhosa-speaking staff’.

Patient(s) indicated some knowledge of the provincial policy, whereas other stakeholders made ‘vague, not in much detail’ reference to the language policy. Stakeholders indicated that the policy is overall, ‘fair, important and necessary’



and definitely plays a role in health, except for the doctor(s), who emphasized “that multilingual use and choice is necessary in practice, not merely in policy”. Similarly, there were mixed reactions to policy success, referring to current slow application of the policy in practice, and that the policy’s success is determined by that. Significantly enough, the patient(s) did not appear to be critical about implementation, but remained generally optimistic about the policy.

### 3) Red Cross Children’s Hospital

There was a vague response as to whether the hospital had an official language policy. Firstly, management indicated that they ‘did not know’ and thereafter said that the language policy provided by the Department of Health is the hospital’s official policy.

**Table 5.6: Knowledge and attitude of stakeholders interviewed at Red Cross Children’s Hospital**

<i>Interviewees</i>	<b>Knowledge of policy</b>	<b>Attitude towards policy</b>
<i>Doctor(s)</i> <i>n=1</i>	No knowledge of policy.	‘To communicate is a practical necessity; you do not need policy to communicate. Also cannot say whether policy will succeed, it depends on the way you are going to implement it...’
<i>Nurse(s)</i> <i>n=1</i>	Vague response. First response was ‘yes, reference to national policy of 11 official languages. However, after follow – up, the response was ‘no’, but then verified first quote after probing.	Thinks it is a good thing – everyone can be included in health, in their own language. Believes policy can succeed, but determined on availability of funding’.
<i>Administration/</i> <i>Management</i> <i>n=1</i>	Yes, reference is made to provincial policy – 3 languages should be made available in written documentation and interpreting facilities.	‘Policy makes sense’ – important to follow or we would be still practising Apartheid. It definitely plays a role in health – quality of services. However, accommodation of policy has to be realistic in terms of finances and increasing influx of immigrants’.



<i>Interpreter(s)</i>  <i>n=2</i>	Vague response and not in detail. Reference is made to examples of 'different languages' and 'each and every person understanding their own language best'.	'Good in promoting equality and must accommodate'. 'Good thing to know different languages, especially in work you are doing'. Believes 'policy will succeed in health'.
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Generally, the stakeholders' knowledge of the policy was rather vague and they knew little detail. The response from administration was not in extensive detail, but provided a sufficient account of the policy in terms of the languages and where these languages were applicable. Regarding policy attitudes, most stakeholders [except doctor(s)] felt the policy objectives were overall, "good and important" in terms of promoting equality and accommodation. The doctor(s) felt that there was no need for a policy in order to communicate, but in practice, it was a necessity. Implementation however was a concern particularly concerning finances and the current context (migration influx and urbanisation).

#### 4) Tygerberg Academic Hospital

The assumption was that there was an official language policy for the hospital. With reference to the policy, management indicated that Afrikaans and English were used along with the eleven official languages. The Public relations department also indicated that the hospital language policy comes from the Provincial Department of Health. Furthermore, the respondent indicated that the general language for the communication of circulars and policies was English. Other notices from the Premier and from the university were communicated in Afrikaans, English and isiXhosa.

There was some knowledge from stakeholders concerning the policy, though not very detailed. The general attitude towards the policy was supportive, and they felt it was 'important and had a role to play in health services', in terms of communication. However, the views concerning whether this policy could be successfully applicable in practice differed. Stakeholders such as management and doctors were concerned about the financial implications of implementing the policy. The Xhosa-speaking interpreters and patients were concerned about

the current context, where policy objectives were not reflected in current practice<sup>44</sup>.

**Table 5.7: Knowledge and attitude of stakeholders interviewed at Tygerberg Hospital**

<i>Interviewees</i>	<b>Knowledge of policy</b>	<b>Attitude towards policy</b>
<i>Patient(s)</i> <i>n=1</i>	Yes, reference to the equal use of the three languages and access.	Supports policy as it can make things easy – plays a role in health. Believes it will succeed and ‘government should apply it as soon as possible’.
<i>Doctor(s)</i> <i>n=1</i>	Yes, reference is made to ‘communication in the language of the patient’s choice and understanding it’.	‘Thinks policy is a good thing’. Welcomes policy but there is cost/financial implications.
<i>Nurse(s)</i> <i>n=1</i>	Yes, but not in detail. Reference is made ‘to respect everybody’s language’.	No issues about policy, does believe it plays a role in health. ‘Cannot say if I support policy as I did not read it thoroughly. However, can only support it in terms of – “it fosters respect for other people’s languages...”’
<i>Administration/Management</i> <i>n=1</i>	Yes, not in detail. Reference is made to ‘the accommodation of people as far as possible’.	‘Policy definitely plays a role, particularly in translation. Policy is important, but does not know if it will be a success due to costs’.
<i>Interpreter(s)</i> <i>n=1</i>	Yes. Reference is made to the provincial policy – 3 languages to be made official in the Western Cape.	Policy will play a big role in public service. Believes policy will succeed ‘if people like us (interpreters) are here and if doctors have a commitment to their patients as they have now’. However, currently ‘what is happening is not what they say [in the policy]’.

<sup>44</sup> See section(s) 5.3 & 5.4, *ibid*.

### 5) Groote Schuur Hospital

According to management, the hospital's language policy is that everything is done "unofficially" in English. Seldom a sign or poster is written in either or both isiXhosa and Afrikaans. They do not take the trouble to translate documents into isiXhosa. This policy has been in place for approximately twelve years.

**Table 5.8: Knowledge and attitude of stakeholders interviewed at Groote Schuur Hospital**

<i>Interviewees</i>	<b>Knowledge of policy</b>	<b>Attitude towards policy</b>
<i>Patient(s)</i> <i>n=1</i>	No knowledge of policy.	Feels comfortable with policy. Believes policy plays a big role in health services and will succeed. However, changed his/her mind about policy success when reflecting on practice.
<i>Doctor(s)</i> <i>n=1</i>	Yes, but rather vague. Emphasis on accommodating patients and accessibility to efficient running of health services.	Feels policy is essential to communicate in health, i.e. 'language barrier. It will be easy to establish rapport with patients and smooth facilitation. However, is 'very sceptical about policy's success – will take a while'.
<i>Nurse(s)</i> <i>n=2</i>	Yes, understood provincial policy as "patient's language of choice" and reference to 3 official languages.	Feels policy is good, and plays a necessary role in health services. Although it tends to people's needs, it is unfair because of pressure to accommodate the influx of 'monolingual speakers'.
<i>Administration/</i> <i>Management</i> <i>n=1</i>	Yes, but not in detail. Shows relative understanding of national and provincial policy.	Where reasonably possible, should try to make it available in all 3 languages. However, it is financially unrealistic, i.e. 'too expensive'.

Respondents generally had vague or little knowledge of the new language policy. Concerning their attitudes towards the policy, the feeling was that many perceive the policy, in terms of its objectives, to be 'good' and that it could play an important role in health services. This was specifically relevant where communication with the patient was concerned. However, there was a general

negative perception that the policy in practice is 'unrealistic, in terms of financing it and the influx of migrants putting pressure on health services.

### **5.3 Comparison of research results in practice for language use in each health facility**

In this section, the views and experiences of patients and health professionals are provided. The views of health professionals in particular, are provided by identifying similarities and differences between doctors, nurses, administrative officials and official interpreters. Subsequently, the researcher's recorded observations of the language issues will be given.

In each facility, stakeholders were asked to describe their language preferences and experiences when interacting with fellow stakeholders and their feelings on languages. The language competency of stakeholders was also determined. The language competency is a measure of the stakeholder's skill or ability to converse in a language adequately. This is based on two different experiences, namely stakeholders from administration and stakeholders comprising doctors, nurses, patients and official interpreters. Administration or management stakeholders' experiences, which are from head office are different, and more formal from the experiences of doctors, nurses, patients and official interpreters.

#### **1) Khayelitsha Site B Community Health Centre (CHC)**

##### **I. Interviews with patient stakeholders**

The respondents' experiences with the facility's staff varied from "very good" to "not bad" overall. Their language competency as well as that of the health professionals they communicate with determined this:

*"My experience with staff is very good because at least I understand English that we communicate with it, and another thing this clinic is in a Xhosa-speaking area. So the doctors are trying to speak basic Xhosa, but I think they need a professional training or interpreters"* [Patient 1, Site B clinic].

*"My experience with staff is not bad, but I don't want to say it is good because doctors are English speaking that I don't know, but with sisters I'm fine because they are Xhosa speaking"* [Patient 2, Site B clinic].

Their language competency in the 3 languages also influenced their feelings towards the languages. In this case, English and isiXhosa were perceived as positive since they could communicate and understand these languages. The respondents nevertheless negatively perceived Afrikaans. English and Afrikaans were perceived to have the highest institutional status (in the Western Cape and Cape Unicity). They felt their language (isiXhosa) was not getting enough institutional support by government and in the public sector, although Xhosa was dominant in the clinic area. They felt that there was a language problem when communicating with staff that did not understand their language:

*"The greatest problems facing the public health sector is language, and shortage of medication, but language is the main problem because people like me, to communicate with doctors, you have to point where exactly the pain is so then he/she can understand you"* [Patient 2, Site B clinic].

Both respondents then emphasized the need for interpreters. There were no feelings from the first respondent regarding foreign African languages. The second patient's feelings were positive towards foreign [African] languages; they should also be accommodated because of the presence of these people in his/her community and foreign doctors.

## **II. Interviews with stakeholders: health professionals**

Each of the respondents indicated that the majority of patients they communicated with were approximately 80% and/or more mother tongue Xhosa speakers. A nurse said that Xhosa needs more institutional support and that English on the other hand is getting more institutional support from government and the general public. Only a percentage (between 1-5%) of Afrikaans was used for communication according to one doctor's experiences. Depending on the language competency, a doctor indicated that the language he would expect to use is English, as he was more competent in it and then combined it with Xhosa clicks. Apart from the defined problems such as shortage of medication and staff, two of the respondents indicated language problems. This was emphasised by an official of administration/management and nurse. The doctor indicated that there were communication problems where staff shortages and resource problems were concerned. Here particular

reference was made to the use of 'interpreters' such as counsellors, nursing assistants and even professional nurses. This was mainly a problem among the nurses:

*"My daily experiences in my field of work is language problems... the huge one is language because we got the patients that are using signal (sign) language, not a single staff member understand that language as a result they end up in a wrong treatment. Also, the Xhosa-speaking they give us a hard time, they give us their history in history rooms but when it comes to be in consulting rooms, they give another story to the doctor.... Government must try to have professional interpreters, these problems can be tackled and we as the staff can also benefit...it can save for us a time"* [Xhosa-speaking nurse, Site B clinic].

*"We are nurses, not interpreters!"* [Administration, Site B clinic].

Furthermore, a doctor felt that there was 'a bit of a problem' to accommodate foreign African and Sign languages. He/she stated 'it is not possible to cater for everybody and that 'it would help if they brought someone along to interpret for them'.

### **III. Personal observations**

The direction or ward allocation signs were sequentially arranged in the three main languages; isiXhosa, English and Afrikaans. Each language is printed on a different colour background, e.g. isiXhosa (dark green), English (light green) and Afrikaans (yellow). Afrikaans is very rarely found in the facility where notices and letters to the public are mainly in Xhosa and some in English. , Xhosa is the dominant language in the facility among patients and Xhosa-speaking staff. English is commonly used among Coloured and white staff who do not speak Xhosa. Similarly, English is the preferred language of communication between Xhosa-speaking staff/patients and non-Xhosa speaking staff. The doctors are predominantly white and Coloured, while the nurses are African (mainly Xhosa). Whenever Xhosa is used for communication, it is mixed with English words amongst Xhosa-speaking staff. The mixing of English and Xhosa clicks or words is similarly used when doctors who do not speak Xhosa communicate with patients.

I was told that a very small population of Coloured patients who live in surrounded areas and foreign Africans come to the clinic. The nurses asked someone to interpret into Afrikaans if they did not understand since the Coloured patients are mainly Afrikaans-speaking. The foreign African patients usually brought someone with them to interpret on their behalf.

During the fieldwork, I had a conversation with a Xhosa patient living in Khayelitsha about her experiences at the clinic. A nurse interpreted in her case, as there were no official interpreters at the clinic. She said she complained that the nurse did not inform the doctor correctly what was wrong with her. She told the doctor that she had chest pains but the nurse interpreted that she suffered from asthma. She got cross with the nurse because she told me the nurse was not conveying the correct information to the doctor. She then told the nurse to keep quiet and wanted to speak to the doctor in English to explain what exactly was wrong with her.

I consequently observed the doctor-patient consultations. I observed at the main clinic section a consultation between a Coloured male doctor and Xhosa-speaking patient(s). The doctor mixed simple Xhosa phrases with his English ('Morse-code' English) with the patient capturing medical terms, i.e. prescribed treatments and parts of the body-'*inci*'. The doctor was very quick examining the patient and he made little or no touching or eye contact with the patient. The patient consistently used Xhosa – his/her own language – to communicate with the doctor. The nurse – the interpreter in this situation – just listened to the doctor, and then spoke to the patient, interpreting what the doctor had just said. The more the doctor spoke in English, the more the patient responded in Xhosa. The nurse then intervened to communicate with the patient, who in turn briefly spoke to the doctor. The patient made frequent eye contact and conversation with the nurse, more often than with the doctor.

The doctor seemed to understand some Xhosa terms and could communicate now and then in Xhosa (at least a sentence or two) but he switched to and made more use of English. In another observation with the same doctor and acting interpreter nurse, both health professionals' actions and manner of



treating the previous patient were the same. He used some Afrikaans phrases to speak to the Xhosa-speaking patient, who responded with an Afrikaans phrase. The patient complained he had a back problem. The doctor also used mixed English and Afrikaans grammar. The patient appeared to respond to the doctor's questions in English or Afrikaans. The patient then turned to the nurse and spoke Xhosa to her. The doctor used a few Xhosa terms, which made it useful. However, the patient maintained close eye contact with the nurse. I noticed that the more the doctor used these Xhosa terms ('*inci*') the more the patient used his language (isiXhosa) and spoke to the nurse instead. Lastly, my assistant observed if there was no sister available to interpret in the consulting room, the doctor had to ask the patient to stand aside and wait until a sister came – whenever that might be. Some doctors understood a little Xhosa, but they still had to learn more, at least the basic things.

## 2) Hottentots Holland Hospital

### I. Interviews with patient stakeholders

Similarly, the patient's experiences with medical staff were determined by language competency:

*"My experience with doctors is good because I understand English and I can hear Afrikaans as well"* [Xhosa-speaking patient, HHH].

Furthermore, the respondent is expected to use English in the workplace and public sector because it is seen as the language that bridges communication between language groups. However, he felt Xhosa as the mother tongue language should also be recognised and should be taught in institutions. Promoting the language "will make him feel at home in the Western Cape". The use of foreign languages such as French in general was negatively perceived in the public sector/workplace and that foreigners (including doctors) should at least know one of the three official languages. Overall, Afrikaans was perceived to have the highest [institutional] status, particularly in the Western Cape. Finally, the patient felt that language and the unavailability of interpreters are problems in health.



## II. Interviews with stakeholders: health professionals

The respondents' general experiences with patients/clients were that they were getting many Xhosa – speakers from the Eastern Cape and many were monolingual and/or illiterate (they only understood/spoke Xhosa, not even English). Moreover, their experiences with patients were generally influenced by their language competency, particularly from most multilingual and bilingual nurses whose experiences were perceived as richer:

*“You relate much better with other people and the people accept you better if you know their language. They don’t...you don’t feel like an outsider if you understand the people’s language. They accept you to a certain extent because they respect the fact that you have learnt their language, but as long as you don’t want to learn their language (even the basics of the language), they’ll always feel threatened by you. They won’t trust you because you...you are disassociating yourself away from them”* [Multilingual nurse, HHH].

A doctor said he did not need an interpreter since he consulted mostly Coloured and white patients who spoke Afrikaans and English. He was competent in these languages, but preferred Afrikaans (his mother tongue). He indicated the staff were able to converse with patients in these two languages. Each respondent also perceived Afrikaans to be the dominant institutional language, specifically in the hospital and surrounding areas.

Administration indicated the language they expected to use in the workplace was the language preferred by the patients, the majority who spoke Afrikaans. Nurses and doctor respondents felt both English and Afrikaans were fine, but as long as they communicated in the language choice of the patient. One nurse said that English should not be a problem ‘as everyone should know the language’. The internal and external documents were mainly in English/Afrikaans and only once a document was translated into Xhosa. According to an administrative official, internal documents coming from the Department of Health are in English only. The problems experienced were mainly [skilled] staff and medical supply shortages, but a language barrier was not highlighted as a direct problem. Respondents said that there was no official Xhosa interpreter and therefore they had to ask a porter or somebody working

in the hospital to interpret for them. Both administration and the nurses indicated this. Foreign African immigrants mostly from Somalia and Sudan were using this facility and experiences with them were described as very difficult. Respondents from nursing and administration also mentioned communication problems between English and Afrikaans speakers, e.g. English doctors conversing with Afrikaans – speaking patients.

### **III. Personal observations**

The direction or ward allocation signs were mainly in Afrikaans and English. Some instructional notices to the public were communicated in all three languages simultaneously. The communication or interaction level was predominantly in Afrikaans. I took a walk through the wards, where the patient population was racially diverse, but there were significantly more Coloured and African patients than white patients. I then proceeded to the outpatient clinics, where I met an aged nurse. She gave me brochures in English and Afrikaans, but she did ask me what my language preference was.

I observed at the antenatal clinic and the outpatient section was very busy that morning as it was usually busy on Mondays and Wednesdays. I noticed the shortage of staff and observed a nurse sometimes assisting two patients at a time. The population was rather diverse and some notices were in Xhosa, although the majority was still only in English and Afrikaans. The language used was mainly Afrikaans and there were mainly white doctors, while nurses and other health officials were mostly Coloured and then African. Staff mostly communicated in Afrikaans, with the exception of African staff, who is iXhosa or some other indigenous language. I had a conversation with a Xhosa – speaking nurse and she said that there was no official interpreter for the hospital and feels there was a need for an interpreter for Xhosa. In this predominantly Afrikaans environment, 'others' had to interpret for her when helping Afrikaans patients. I observed that the nurse was able to communicate fluently with Xhosa patients. The nurse could communicate in English but not much in Afrikaans as she said it was a difficult language and she struggled with it. I also noticed that there were Coloured patients who automatically conversed with her in English.

### 3) Red Cross Children's Hospital

#### **I. Interviews with stakeholders: health professionals**

Management and administration stated that 'written external documents (e.g. newsletters) were in English and documentation from head office made use of all three official languages, but it was predominantly in Afrikaans and English for official or main documents. A doctor indicated everyone was exposed to English and less Afrikaans was used as fewer people were using Afrikaans, hence it was becoming more marginalised'. There are differences in the way doctor(s) and nurses(s) communicated to child patients and their parents/guardians. A doctor indicated that he/she used "pigeon Xhosa" (one or two Xhosa words/phrases) in combination with English, particularly with patients coming from the Eastern Cape who were mainly monolingual Xhosa.

According to an official interpreter, there were doctors who learnt Xhosa terminology as a teacher occasionally came to the hospital to give Xhosa lessons. Alternatively, a nurse said that she spoke English to English/Xhosa speaking patients/guardians and Afrikaans to Afrikaans-speaking patients, therefore, "there is no language barrier". Moreover, English was widely practiced and expected as the language to be used in the workplace. Afrikaans and isiXhosa were not getting the same institutional support as English. The doctor, official interpreters and nurse generally indicated this.

Those that indicated that either Afrikaans or isiXhosa was getting less institutional support, their mother tongue language was also in either Afrikaans or isiXhosa. The overall language used among staff was mainly English, then Afrikaans and finally Xhosa. Although, the nurse and interpreters had different experiences in communicating with patients, they generally felt that English and isiXhosa were used most often in communication with patients. Nurses, doctors, official interpreters as well as administration shared the feeling, that foreign African immigrants made use of the facility. It was regarded as a problem area in terms of communication and they either brought someone to interpret on their behalf or the hospital arranged for the security guards to

interpret in either French or Portuguese. Interpreters were perceived positively at the facility since they were seen as “scarce and essential to health”.

The experiences of interpreters differed from that of other health professionals:

*“Not enough support, few Xhosa speaking people are accommodated; Xhosa is accommodated because an interpreter is here but it was worse before. Now some Xhosa-speaking patients come looking for me, but some of the doctors are impatient and ask other family members or any other Xhosa-speaking person to quickly interpret”* [Xhosa interpreter, RCH].

## **II. Personal observations**

The language used in the facility was mainly Afrikaans (among Coloured staff), but they often addressed me in English. The doctors (mainly white) generally communicated in English. However, among patients/clients the use of Afrikaans and English was prevalent. In terms of external communication, the signages were generally in monolingual English. The new signs, newsletters and brochures were also only in English. In the Social Work section, information posters were in Afrikaans and Xhosa. Signage in Afrikaans and English was rare in the facility. In the main entrance to the hospital, the departmental directory was only in English. At the reception area, the three official languages were evident where I observed some Coloured staff conversing in isiXhosa over the phone.

The patient/client population waiting at reception was mainly African and then Coloured. I had a conversation with a staff member who indicated that there were incidences of language/cultural barriers in the facility and felt that this problem should be highlighted in order to be addressed. On a walk through the clinic, we came across an elderly doctor attempting to communicate with the patient's mother/guardian in isiXhosa with the assistance of a nurse. It was evident that doctors were not always making use of the officially trained medical interpreters, which was confirmed by a respondent.

Further observations were then conducted with the official interpreter(s) in the consulting rooms. There were two officially trained interpreters on a full-time

basis at the hospital, which was made possible by private funding. There was one instance where a monolingual English (foreign) doctor would consult Afrikaans-speaking patients/guardians via another doctor who could understand and speak [broken] Afrikaans. The Xhosa interpreter(s) used hand gestures or Sign Language to explain/interpret medical jargon such as “nebulisation” to the guardian. In other words, the interpreter would try to explain it in simpler terms, i.e. “putting the hands over the nose”. The use of pure Xhosa with a little English was frequent in the interpretation during certain time intervals. The doctor would ask whether the patient fully understood and the patient would then acknowledge (nodding her head) to the interpreter and doctor that she understood. The interpreter said she mainly conversed in English and Xhosa (with her own Xhosa-speaking people) and used English with Afrikaans and other English-speaking people.

#### 4) Tygerberg Hospital

##### I. Interviews with patient stakeholders

The respondent expressed that there was a language barrier in her experiences as a patient at the facility:

*“I got a problem even now my folder is written in Afrikaans that I don’t understand, and my fear is that if anyone who understands Afrikaans can come in my ward and read my folder. He/She is going to know what I’m here for although I will be unaware of that...I’m not happy about that”* [A Xhosa – speaking patient, TBH].

No language was singled out as the expected language of communication and preference was given to all three official languages in this regard. He/she felt that isiXhosa required more institutional support and had to be maintained in the public sector. English and Afrikaans were perceived to have the highest status in the Western Cape. There was also negative sentiment concerning the use of foreign [African] languages in the workplace/public sector, as the policy ‘only accommodated the three languages of the Western Cape’.

The daily experiences with health professionals were mainly based on the respondent’s language competency. This meant that if the patient was able to converse in [even basic] English and the health professional was also primarily

English, then their experience was not interpreted "as bad". Furthermore, the patient(s) felt positive towards the presence of interpreters as this would "help eliminate misunderstandings between patients and doctors".

## **II. Interviews with stakeholders: health professionals**

In management and administration, the internal and external documents were predominantly in English and Afrikaans according to a respondent from administration. An interpreter stated, "It is on very rare occasions when English, Afrikaans and isiXhosa appear on public signage/notice boards. There was a consensus among respondents that an influx of [monolingual] Xhosa speakers and foreign Africans (mostly French-speaking and Somali) caused problems in communication. According to a doctor, there was no official interpreter after hours and thus a Xhosa-speaking nurse or patient was asked to interpret. He/she also indicated 'Foreign African patients normally brought along family members to interpret on their behalf, or staff would try to communicate using Sign Language/hand gestures'. A nurse also confirmed this. One respondent indicated that if the patient understood English there was no need for an interpreter. Overall, respondents perceived the general language population among both staff and patients to be predominantly English and Afrikaans. Among patients, there were mostly Afrikaans speakers, then English, isiXhosa and a small minority of foreign African immigrants. The many perceived difficulties were the language problem as well as financial, medical supply shortages, and overworked staff.

A doctor who also emphasised communication problems or a language barrier in his/her experiences with patients indicated this. The facility's only official interpreter had significant experiences in his/her daily interaction with patients and health professionals:

*"You know I have learnt a lot and this is stressful I must tell you this. Last month I had a patient, a fifteen year old came to give birth but she doesn't know any...she doesn't know what the doctor or the nurse wanted to communicate with her. I have, it's the first time, I'm forty-six years old but it was the first time ever since that I saw somebody giving birth...I couldn't eat that day...I go into labour wards...these critical wards where some people switch off that they can't*

*talk. Then I must learn to talk with my hands and tell the person to look at my mouth. That's why I want to learn Sign Language..."*

There was also a feeling from a Xhosa respondent that the language was deteriorating as the language was 'mixed with English' and that people did not want to speak Xhosa. Some felt that Afrikaans is the language expected to be used in the workplace so that the majority of Afrikaans-speaking patients could be catered for. English was generally perceived to be achieving higher institutional status. They nevertheless felt that this would be difficult to achieve due to the problems mentioned.

### **III. Personal observations**

Management and administration used mainly English and Afrikaans for written communication. The documentation from the head office was often only in English. There were a few odd pamphlets and brochures available in all three languages. The interpreter usually translated or edited documents for the public such as medical accounts, from English to isiXhosa, and visa versa.

Notices and signs were mainly in English and Afrikaans (has greater preference) but there were a few new signs in all three official languages. A Xhosa respondent replied that the correct Xhosa is 'not properly communicated on one of those signs and told one of them to take it down'. He/she said it eventually "took them two years to take one of the signs down".

I then observed in the consulting rooms where the interpreter was present with the doctor and patient. In each observation, I would briefly introduce myself to the doctor and then the patient and asked their permission to observe. The doctors normally agreed depending on whether the patient was comfortable. The interpreter would interpret to the patient on my behalf and the patient would then nod in agreement if he/she was comfortable. The observation was based on a consultation on an abortion procedure. The consultation was very important as the doctor had to brief the patient and explain the exact procedure of the abortion as well as the effects. Once the patient understood this she had to sign the letter for authorization, which was in English and Afrikaans. Without



the signature of the patient, the procedure could not continue. The doctor appeared to be English-speaking and first spoke to the interpreter. The interpreter then leaned forward and concentrated on what the doctor was saying. The interpreter turned to the patient and slowly communicated in Xhosa what the doctor said to her. The patient continuously made eye contact with the interpreter and nodded at what the interpreter had to say. The interpreter then turned to the doctor, nodded, and said "mmm". In other words, the doctor knew that the patient understood the information. The doctor repeated the conversation and the interpreter leaned forward once again. The interpreter asked the doctor to repeat what she had said, probably because the doctor had a lot to say. The interpreter slowly interpreted what the doctor said in Xhosa and helped the patient to sign the consent forms.

The consultation contained vital information on the patient's choice and reason for the abortion. In addition, the patient was made aware of the effects of the abortion procedure that she would have to endure. It was therefore important that the patient understood this. The patient claimed that the reason for her wanting the abortion was that she and her husband were on the brink of a separation and due to her social circumstances that she had three children and that was enough. She could not afford another baby. The patient was in a great deal of pain and discomfort (vomiting and nausea). I assumed that it might have been from the medication or something that the patient had taken. The doctor did explain it but I cannot remember what the doctor said at that moment. After the consultation, I spoke to the doctor and asked her what her impression of having the interpreter with her was. The doctor exclaimed that the interpreter was essential and that she did not know what she would have done without the interpreter. The interpreter made a valuable contribution to her work with patients especially with those that could not understand what she (the doctor) was saying. I then asked the patient and she said that the interpreter had interpreted to her correctly and that she understood what the doctor had said in the room.



## 6) Groote Schuur Hospital

### I. Interviews with patient stakeholders

The respondent equated her problematic experiences in health to her low educational status (former Bantu Education). She was monolingual (Xhosa) and thus always required someone to interpret for her in the consulting room. She described her experiences in communicating with health professionals and other people in the facility regarding language competency:

*"My experience with staff is bad because doctors are English-speaking that I don't know, but with sisters (nurses) I'm fine because mostly they are Xhosa speaking. My ward mate is Afrikaans-speaking so I don't communicate with her, if I feel like to talk to someone I have to get out of my ward and find someone who is also speaking my language."* [Xhosa-speaking patient, GSH].

The patient had a negative attitude towards English and Afrikaans due to her poor language competency in them. IsiXhosa was her mother tongue and thus she felt comfortable with it. The respondent felt the language is not getting enough institutional support from government, as this was 'a world of English and Afrikaans'. The language expected to be used in the work or public space was isiXhosa or if there were interpreters it would make her 'feel at home or comfortable'. Moreover, the respondent indicated a negative attitude towards the use of foreign [African] languages:

*"I got nothing to say about foreign languages because I'm suffering from these too in my country, so I don't want to comment...but on my side I won't speak or learn foreign language"* [Xhosa speaking patient, GSH].

### II. Interviews with stakeholders: health professionals

Management and administration's external documents are communicated mainly in English, sometimes in English and Afrikaans, but Xhosa was seldom added. The internal documents were only in English. On all levels the need for translators/interpreters was strongly emphasized. There were staff such as nurses, clinicians and even patients who interpreted on a voluntary basis:

*"Die nurse moet haar werk los om te gaan tolk en dit vat lank om te verduidelik met Xhosa pasiënte. Dis nodig om 'n amptelike tolk te hê soos 'n maatskaplike werker in die professionele sin. 'n Tolk sal makliker wees maar 'n suster sal*

*nou nie verstaan nie, so daar moet taalkommunikasie wees veral by ontslag (van pasiënte), dis moeilik daar...*"<sup>45</sup>[Afrikaans-speaking nurse, GSH].

*"Interpreters would make a difference I remember we used to have a Khoisan patient who would be lying there until you get an interpreter. So interpreters are invaluable"* [SiSwati-speaking doctor, GSH].

There was consensus over certain problems highlighted in their daily experiences such as staff shortages, language/communication problems and attitudes to learning a new language(s). Subsequently, they usually used hand gestures to Xhosa and foreign African immigrants, mainly French or Portuguese speaking. There were Xhosa speakers that understood a little English and maybe Afrikaans and there were people from the rural areas who mainly spoke Afrikaans. There were a very small percentage of deaf patients, but they brought their own interpreters.

The respondent's indicated that the language use among the staff was diverse, with English (+60%) among mostly white health professionals and Afrikaans (+15%), isiXhosa (15%) and other languages (10%) among black staff. These estimations vary among respondents as they were based on their daily interactions, which were unique in each case. Based on each respondent's view the facility was with English and Afrikaans as the two main languages used among staff. The patient population was mostly Xhosa and Afrikaans-speaking according to respondents. Their attitude to various languages was based on their language competency ('I understand English, therefore I am happy...'). English was more favourably perceived in the facility as health professionals felt it helped to bridge the language gap especially with minority language groups such as foreign African and Xhosa migrants. It was also perceived as the language receiving greater institutional and international support (the 'unifying language').

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<sup>45</sup> *"The nurse must leave her work to go and interpret and it takes a long time to explain to Xhosa patients. It is necessary to have an official interpreter such as a social worker, in the professional sense. An interpreter will be easier but a nurse will not understand, so there must be language communication especially where patients are discharged; it is difficult there..."* [English translation].

Alternatively, Afrikaans was not getting enough institutional support and isiXhosa has a place and should be learned by health professionals due to the influx of Xhosa migrants. Although Xhosa lessons were encouraged, the respondent(s) felt that the time slots for that interfered with their lunchtime (seen as a labour right)<sup>46</sup>. There was a negative attitude towards foreign African languages:

*"I don't think we should expect ourselves to learn [French] for them, rather they should speak English. It is unreasonable...one should look at the demography, which is mostly Xhosa..."* [English-speaking nurse, GSH].

### III. Personal observations

Observations were recorded on Wednesday mornings and Thursday afternoons (busier times) at the main outpatient clinic and the maternity unit. There were mostly Coloured (majority) and African patients waiting in the outpatient area. There was a very small population of white patients. The public notices were in English and a few in Afrikaans (*"Skakel u selfoon asseblief af wanneer u in konsultasie met die dokter is"*)<sup>47</sup>. Further notices and signage at the entrance of the outpatient area were in the three official languages.

In the specialised clinics it was either English and/or Afrikaans, except for the toilet signs on one floor that was trilingual – 'Women, Vroue, Abafazi'. The mixing of English and Afrikaans, e.g. *"Het jy al 'n injection gekry?"*<sup>48</sup>, was also observed mainly among Coloured nursing staff. In the maternity unit on ground floor, the entrance signs were only in English. English is generally used among the white patient and staff population, as well as African health professionals who interact with opposite race groups.

I then conducted an observation in the consultation room at one of the clinics. The doctor was black and spoke fluent English and he had three medical intern students with him. The one intern was Coloured and spoke English while the other two were Xhosa and spoke fluent English. An elderly Xhosa couple were consulting the doctor on their ability to get pregnant again. Significantly, the two

<sup>46</sup> Termed a 'structural contradiction'.

<sup>47</sup> *"Please switch off your cell phone when in consultation with doctor"* [English translation].

<sup>48</sup> *"Did you get an injection already?"*. The Afrikaans word for injection is *'inspuiting'*.

Xhosa interns were acting as the interpreters as there was no official interpreter at the hospital. The Coloured intern worked with the doctor recording the observations in medical jargon. The doctor attempted to speak to the patients but the female patient was rather reluctant to respond.

The medical intern then intervened by conveying to the patient what the doctor had just said. She (acting interpreter) then smiled half-heartedly at a question the doctor posed, "How often are you having sex, erectile disfunctions?" The doctor attempted to establish eye contact with both the 'acting' interpreter and patients during the examination, but eventually he concentrated on the medical interns (acting interpreters). The doctor asked them to explain to the patients what 'genes' were in order to clarify why they were not reproductive. The interpreters found it very hard to explain this terminology to the patients, as there was no exact Xhosa term for 'genes'. When they tried to explain, both patients did not seem to understand as there was a blank expression on their faces and they did not answer the interns. The interns attempted to interpret and explained to the patients once again, but the patients were quiet.

This appeared to be the most difficult part of interpreting, since there was a biological explanation with difficult terms that the patients could not understand. I presumed they were not able to get the patients to understand as the doctor replied, 'I don't know how they are going to explain what genes are, but I will refer them to the place (special unit)'. I also observed the body language of the medical intern acting as an interpreter. She was fidgeting with her hands and there was an anxious and nervous look on her face. I confronted her about this. She said it was very difficult for her as she was in a 'complex' position culturally to speak about sexual issues to elderly people. She also mentioned that the elderly couple were illiterate.

I stayed to make another observation with a second Xhosa-speaking patient. The doctor conversed with her in English and the patient responded in English. The doctor also saw a foreign African patient (French speaking) and the doctor seemed to converse fluently with her in English, and she equally responded to the questions. I had a conversation with a foreign doctor and he discussed the

language difficulties he faced particularly regarding Xhosa and Afrikaans-speaking patients.

#### **5.4 The big question: are there any gaps?**

This section attempts to establish whether a gap exists based on the research results in each health facility. The gap describes how far policy ideals diverge from what is actually occurring in practice in public health in the Cape Unicity. Each health facility is based on the empirical evidence presented in the previous sections. Thereafter, comparisons are made concerning the similarities and differences for the health facilities investigated.

##### **1) Khayelitsha Site B Community Health Centre (CHC)**

A significant gap is evident between policy objectives and realities in practice at the facility. This is based on a number of inferences. Firstly, the concern from management that 'there is no language policy for the facility'. This is contrary to the principle of 'functional multilingualism' since there is no agreement on a working language(s). Secondly, the patient(s) indicated communication difficulty with non – Xhosa speaking staff who were English/Afrikaans speaking doctors and other health professionals. This included misinformation about the patient's history, where the Xhosa-speaking nurse's information on the patient differs from the doctor's information given by the patient. Hence, there is a violation of the Batho Pele health policy stating "the patient should provide health personnel with relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes".

It is clear that the language barrier causes difficulty in making this applicable in practice. Management and administration still, in Afrikaans and/or English. This is then contrary to the policy, which emphasises "the use of the three languages in written, translated, edited and spoken forms for internal and external communication" (De Vries, 2003). Thirdly, patients are made to wait for a voluntary nurse to interpret on their behalf, since there is no official medical interpreter for the facility.

There is a vast difference in the manner in which the voluntary nurse and the officially trained medical interpreters at Tygerberg and Red Cross Hospitals interpret. The voluntary nurses do not ask for clarification or confirmation, neither does the nurse speak carefully (slowly and clearly) or make use of hand signs/gestures to interpret terminology.

## 2) Hottentots Holland Hospital

Although the majority is taken into consideration as well as the patients' language preference, there are a number of features that illustrate a gap between policy and practice. The hospital's policy is based on the language demography of the environment, which is mainly Afrikaans and English. There is a growing influx of African (isiXhosa) patients mainly migrants from the Eastern Cape. These patients are mainly monolingual in Xhosa and cannot even understand basic English. There are no officially trained medical interpreters available to interpret and adequately ensure the patient's right "to access to health care services, specifically treatment and rehabilitation that must be made known and understood by the patient". Although the patient's language preference is respected in this setting, it nevertheless reflects the majority Afrikaans and English population. There is little accommodation (or the quality thereof) for the growing 'minority' of [monolingual] Xhosa speakers, whose language preference is their mother tongue. The use of informal interpreters such as the porter, or 'someone in the hospital' may ensure that 'every effort must be made to make use of translation or interpreting services, where practically possible', but at the expense of the patient's above-mentioned rights.

## 3) Red Cross Children's Hospital

The Western Cape Language Policy and therefore also the official policy of the Department of Health emphasizes the promotion and equal use of the three official languages of the Western Cape.

Alternatively, English (predominant) and Afrikaans are the strongest languages of communication in written internal/external documents. There are two full-time

interpreters (privately – funded), but they are overburdened as the workload is too much for the hospital. This is evident upon both observations where doctors used a Xhosa nurse and a family member to interpret on separate occasions, since the interpreter was not on time. Thus, there are structural contradictions in place for the nurse (as emphasised in Khayelitsha) as well as confidentiality/privacy limitations for the patient. Equal and fair treatment is questioned when comparing the quality health care of mother tongue English and Afrikaans speakers. Foreign African immigrants who are mainly French and/or Portuguese speaking use the parking/security guards to interpret or they bring someone along to interpret. There are foreign doctors who may be competent in English, but have difficulty with many Afrikaans-speaking patients/clients, many coming from the rural areas.

There is an attempt to promote and foster isiXhosa for the influx of patients mainly from the Eastern Cape and the surrounding Cape Metro, which reduces the gap to some extent. Xhosa is not given equal status in written communication and there is a language barrier between foreign health professionals and Afrikaans speaking patients/clients.

#### 4) Tygerberg Hospital

There appears to be evidence of a language barrier between the patient(s) interviewed and the language policy of the hospital. Even though folders are intended for hospital staff only, it is clear the patient (quoted above) feels discriminated against since she does not understand the language that is used. Thus, she cannot be adequately informed of her condition nor exercise the right to confidentiality/privacy concerning her health status. There is a single officially trained medical interpreter for the entire [main] hospital who conducts written and spoken translations. Similar to the interpreters' experiences at Red Cross Hospital, the respondent is overloaded with work and feels that the deployment of another interpreter would be advantageous. Moreover, the interpreter is knowledgeable about cultural implications, which also widens the communication gap between patient and health professional. Subsequently, there is evidence that the doctors make use of a Xhosa-speaking nurse, patient, porter or family member to interpret especially after hours. This is done



for the purpose of accommodating the language/communication barrier to treat the patient immediately.

#### 5) Groote Schuur Hospital

The language gap is rather extensive since there is no officially trained medical interpreter. The language problems are evident in the observations made where the medical interns cannot explain or describe what is wrong with the patient. They are therefore not being properly informed about their condition since they do not understand what the doctor is trying to convey. Foreign health professionals have some difficulties with the language diversity in the hospital as Afrikaans and isiXhosa cause problems for them. Indirect written communication (e.g. instructions) and signage are predominantly in English and Afrikaans. English is presumed to be the language of communication, which Xhosa-speaking people are expected to understand. There is evidence of monolingual Xhosa-speaking patients in the hospital who cannot speak even basic English. Similarly, foreign African patients are also presumed to use English to bridge the language barrier with the health professional.

### **5.5 Conclusion**

This chapter presents empirical research results in order to establish related practice as well as the gap between policy and practice in each facility. Tables are presented for each facility regarding the respondents' aptitude and attitude regarding the policy. The language policy for each health facility is also investigated and presented in section 5.2. In section 5.3 comparisons are made on the related practice in each health facility. The results are presented in three sections namely; 1) interviews with patients, 2) interviews with health professionals (including interpreters where applicable), and 3) personal observations.

Finally, the extent of a gap between policy objectives and related practice in the research results is established in section 5.4. The gap can be conclusively linked to each observed health facility in the Cape Unicity. The gap is bigger in facilities such as Khayelitsha, Hottentots Holland and Groote Schuur Hospital. Significantly, these facilities lack the availability of a professionally trained



medical interpreter for the growing Xhosa-speaking population in the Cape Unicity.

Patients tend to relate positive experiences in health services when there is a health professional who understands and/or speaks their mother tongue e.g. 'there is an interpreter so my language is accommodated'. Another concern is the dominance of English and Afrikaans in written communication in each health facility. There is evidence that suggests English and Afrikaans are the predominant written languages, as well as English as the language persons presume to understand and converse in. In facilities that provide the services of officially trained interpreters, the quality of treatment and care complies with the Batho Pele principles as well as that of the language policy. There are doctors who still make use of nurses, porters, patients and the patient's family members to act as interpreters. This is due to the lack of officially trained interpreters and the high workload, making it impossible for the available interpreters to cater for the entire staff and Xhosa-speaking patient population at facilities.

The Xhosa-speaking population is relatively under serviced compared to the Afrikaans and English speaking populations in the Cape Unicity. This means that "there is an increased likelihood that Xhosa speaking individuals because of their membership in a certain group, experience difficulties in obtaining needed care; receive less or lower standard care; or experience differences in treatment by a health professional; receive treatment that does not adequately recognize their needs; or be less satisfied with health care services" (Bowen, 2003: 102).

# CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

## 6.1 Conclusion

The study explores language diversity by looking at policy application in practice in the public health sector in the Cape Unicity. This is done in order to determine the existence of a gap between policy objectives and practice. This is presented in chapter one and substantiated in chapter two.

It is also important to examine the context in which the study takes place. I observe the historical and current socio – political context of language and health in the broader South African (national), and both Western Cape (provincial) and the Cape Unicity (local). This is done since both language and health policies are interrelated or concurrent in terms of governance. The study is conducted using qualitative methods such as participant and natural observation, as well as in – depth and semi – structured interviewing. The research results can be established by using case and situation analysis (Burawoy, 1998). This is examined in chapter four. The empirical research results and conclusions for each health facility are presented in chapter five.

According to the research results, there is a significant gap in the public health facilities in the Cape Unicity. It is less extensive in health facilities where officially trained interpreters are based. This demonstrates the impact of officially trained interpreters in meeting policy objectives as well as contributing to positive attitudes of stakeholders regarding the vitality of marginalised languages. There is also evidence that minority language groups (foreign African languages) and particularly Xhosa speaking individuals, do not share equal status with English or Afrikaans (including bilingual) persons) in health services. Accordingly, a number of policy recommendations and prospects for future research are outlined.

However, there are a number of limitations in the study, which are substantiated.

a). Given the methodology chosen and difficulties of access, the results of this work should be seen as exploratory and not strictly generalisable. However, results indicate clearly that a gap between policy and practice exists and suggest what the nature of this gap is.

b). The selection criterion of patients (pg. 42) was Xhosa speaking informants. Since, the study is exploratory only a small sample of patients were chosen.

c) Since the nature of the setting is unpredictable, there is no single means of ensuring interview control. Hence, various methods of obtaining data had to be applied. Depending on the situation (e.g. time constraints), data were retrieved often by casual conversation based on a discussion on the questions in the interview guide. Formal interviews that were carried out were conducted with respondents in administration or management levels.

d) It was anticipated that respondent-interviewer effects would occur. The possibility that the respondents' views were 'biased' or based on 'half-truths', therefore cannot be ruled out. In some tertiary facilities, moreover, interview saturation may have taken place as well as the 'Hawthorne effect', where respondents may have altered their behaviour or thoughts when approached.

## 6.2 Need for further research

There are two features, which can be highlighted.

Firstly the population of both patient and health professional stakeholders should be properly established by means of conducting a quantitative survey, since the population in a given health setting is generally unknown (Ferreira, 1982). No extensive information on language and gender currently exists for stakeholders in public health, and the information would be beneficial for future research. Secondly, similar language-related studies of policy and practice are encouraged in sectors such as education, law and commerce particularly where language implications are considered important.

## 6.3 Policy recommendations

Having achieved the purpose and the objectives of the study, the following recommendations are proposed:

- Even though it is unrealistic to include knowledge of sign or minority languages in the policy, a feasible strategy is recommended to promote awareness and develop proactive strategies concerning the inclusion of minority language groups in health services in future.
- Recognise official medical interpreters as a 'related profession' in health services, being similar to the status of a social worker, psychologist or physiotherapist.
- Predetermine how many permanent official interpreters are required, depending on the patient and language population of a health facility. It is recommended that at least three permanent Xhosa interpreters are needed at a tertiary level facility.
- Include Afrikaans-speaking official interpreters to bridge the language barrier between monolingual foreign doctors and the predominantly Afrikaans-speaking population in the Cape Unicity.
- Evaluate economic costs of implementation strategies but equally long – term costs in the interest of the patient, e.g. right to privacy contrary to complexities in involving family members in patient's health (possibility of stigma).

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## Appendix I

**INTERVIEW GUIDE<sup>1</sup> (For administration/management respondents only)****Paper 1: Policy aspects****June 2004**

1. Sex
2. Age
3. Race
4. Home language (Probe: any other languages?)
5. Religious Affiliation
6. Highest Education level
7. Current Employment status (i.e. part-time, full-time, casual, unemployed- looking or not looking for work).
8. Work Status (even if unemployed, what would they consider as their main occupation?).
9. Do you have any understanding of the current language policy framework? Briefly, explain. [IF YES, CONTINUE WITH INTERVIEW].
10. To clarify, does your hospital or clinic have an official language policy?  
When and how long has this policy been in place?
11. According to the Department of Health, the implementation of a language policy for health is currently underway or "going through a process of change". What is your view on the above statement?  
Explain (probing i.e. implementation strategies).

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<sup>1</sup> Interview guide to be verbally translated into Afrikaans & Xhosa in the interviews.

12. Your feelings on the current multilingual policy? (What role do you think language policy may play in public health services? (Your view)- (Probe) Do you think it will succeed in the public health sector? Your rating.
13. The Department of Health anticipated a number of language policy implications (name a few) for health care facilities. What is your response to the above statement? Has this become evident in your setting? Your view on this impact? (Probing-existence of interpreters). What language(s) is communicated frequently among staff at this hospital or clinic?
14. Likewise, of the patients? Do you have a demographic profile (e.g. ratio, stats) of patients and staff?
15. Regarding internal and external documents, what is the language(s) in which these documents are (a) written, (b) translated and (3) edited?

**INTERVIEW GUIDE****Paper 2: Practice****June 2004**

1. Sex
2. Age
3. Race
4. Home language (Probe: any other languages used?)
5. Religious Affiliation
6. Highest Education level
7. Current Employment status (i.e. part-time, full-time, casual, unemployed- looking or not looking for work).
8. Work Status (even if unemployed, what would they consider as their main occupation?).
9. Health Status
10. Residential area
11. Marital Status
12. What is your understanding of the current language policy framework?  
Briefly, explain. [IF YES, CONTINUE WITH INTERVIEW].
13. Your feelings on the current multilingual policy? (What role do you think language policy may play in public health services? (Your view)-  
(Probe) Do you think it will succeed in the public health sector? Your rating.
28. What are your daily experiences in interacting with patients, staff, etc in your field of activity? (Please describe).

30. The Department of Health anticipated a number of language policy implications (name a few) for health care facilities. What is your response to the above statement? Has this become evident in your setting? Your view on this impact? (Probing-existence of interpreters).

31. According to various media reports, the public health sector is arguably 'deteriorating' and experiencing problems. What would you say are the greatest problems facing the state health sector today? [Probe whether problems are language-related-language barrier problem?] Do you have suggestions for tackling these problems?

32. What would you say are the two greatest problems within your field of activity? Do you have suggestions for tackling them?

33. In general (particularly in the workplace), what are your feelings on the following: 1) English?

2) Afrikaans?

3) isiXhosa?

4) Foreign African languages and/or Sign languages?

34. What do you think, in what language would you expect to use in the workplace? [Probe: why?]

35. What do you think, in what language would you expect to use in the workplace? [Probe: why]

36. How would you rank the language use or its status in your setting? [Please estimate and describe language use among staff & patients].

## Appendix II

18 Vasco Street  
Brooklyn  
7405

The UCT Research Ethics Committee  
Main Road  
Observatory

Dear All

**Re: LANGUAGE DIVERSITY IN THE CAPE UNICITY PUBLIC SECTOR:  
POLICY AND PRACTICE**

I am writing this letter for the purpose of clarifying anything that seemed vague to you in my protocol and proposal. I have highlighted the following explanations on issues that was made mention of, which I failed to clarify adequately. The issues that were brought up was informed consent, confidentiality concerning the involvement of my assistant/translator and I shall make mention of changes concerning my research design and methodology.

- Respondents and observed subjects informed of the nature of the study in the language of their choice in order to discourage deception. Thereafter, they are asked whether they would like to participate in an interview or if they are comfortable with me and my assistant to observe. We assure them that their opinion and views are respected and strictly confidential and whatever their decision, nothing will be held against them if they do not wish to participate. Thus, the subject has the right to freely withdraw and they are free to ask any questions pertaining to the study and researcher/s. Although informed consent is asked and given verbally, I have attached the informed consent in writing (see addenda), in the manner, which I interact with potential subjects.
- For Groote Schuur, I wish to interview 5 persons in one selected clinic. The 5 subjects will consist of 1 doctor, 1 nurse, 1 person in admin/management concerning communication in the clinic, 1 interpreter and 1 Xhosa-speaking patient (either in or out-patient). In the case where the interpreter is absent, I would substitute the subject for another nurse or social worker. I do work within a certain time limit at a setting to a maximum of 1 week.
- Concerning the involvement of my translator/assistant, I cannot entirely guarantee the assurance of confidentiality. However, the nature of our working relationship is strongly built on trust and I hold peer reviews in prior and post interviews and observations on the importance of maintaining confidentiality. I have also instructed him/her strictly not to discuss the interviews, respondents or observed consultations, only as far as the nature of the study is concerned to outside peers. We have coded the interview transcripts and observations to protect anonymity and assure confidentiality. So I aim to, in my best efforts do my utmost to respect the confidentiality of my subjects.



- I have undergone a few changes in my research methodology, though my design remains the same. My research design is ultimately qualitative in nature and aimed at exploring policy implications, views and attitudes on languages in relation to the Cape metro (public)health sector. I conduct in-depth interviews, participant observations and casual conversations with persons within the setting. Due to the nature and conditions of the public health settings, I have abandoned random systematic sampling and other rigid methods of selecting subjects. Alternatively, I opted for 'convenience' sampling (whoever is available and willing to participate) and snowball sampling (referrals and recommending the next best person) methods. Thus, my study encourages flexibility and may well suite the nature of the setting.

I hope the above explanations satisfies the requirements which you have strictly emphasized. If not, please do not hesitate to contact me as soon as possible. I apologize for any inconvenience that I may have caused in being too vague or inconcise in my synopsis. Also, much appreciation and thanks for the reviews and for your response to my study. Understandably any researcher would respect the decisions made by the committee and acknowledge the importance, of his/her/their study being ethically sound and of the highest standard.

Many thanks

Michellene Williams

Tel: (012) 510 3174 [H]

Cell: 072 612 5616

E-mail: 13485407@sun.ac.za

#### ADDENDUM: INFORMED CONSENT IN WRITTEN FORM

*"Hi, my name is Michellene [Cases where Xhosa patient is asked: "and this is my assistant,.....]. How are you? I/We am/are currently conducting research on language diversity in state hospitals and clinics. Basically, I am interviewing doctors, nurses, interpreters and other practioners in various medical settings on their feelings on language use and the language policy and implementation strategies (use of interpreters and promotion of official languages). Would you be willing to do an interview in your own time as your views are important and would make an important contribution to future policy making decisions. I/We can assure you that everything you say and do is anonymous and strictly confidential. Also, you have the right to withdraw at any time and nothing will be held against you. Whatever you do or say shall be respected."*

At times, we do get more questions posed from potential respondents such as "Where are you from?" or "Tell me more about yourself or the study..." In turn, I/we do my/our utmost in being open and honest about ourselves, since we want subjects to be comfortable at all times.

I do approach subjects in the language of their choice, including informed consent. Likewise, Xhosa patients are also approached in the manner communicated above as translated by my assistant. However, I apologize that I was unable to attach a Xhosa translation of the above as my assistant is bound by time and distance constraints. Furthermore, I am currently limited by such short notice, time and financial situations.

UNIVERSITY OF CAPE TOWN



Research Ethics Committee  
E53 Room 44.1, Old Main Building Groote  
Schoor Hospital, Observatory, 7925  
Queries : Xolile Fula  
Tel : (021) 406-6492 Fax: 406-6411  
E-mail : Xfula@curie.uct.ac.za

01 September 2004

REC REF: 247/2004

Ms M Williams  
18 Vasco Street  
Brooklyn  
7405

Dear Ms Williams

LANGUAGE DIVERSITY IN THE CAPE UNICITY PUBLIC SECTOR: POLICY AND PRACTICE

*Thank you for submitting your study to the Research Ethics Committee for review.*

*It is a pleasure to inform you that the Ethics Committee has formally approved the above-mentioned study on the 30<sup>th</sup> August 2004.*

*Your comments to the queries raised are noted with thanks.*

Please quote the REC. REF in all your correspondence

Yours sincerely

  
PROF. T. ZABOW  
CHAIRPERSON

**Research at Groote Schuur Hospital**

Leigh Pollio [Lpollio@pgwc.gov.za]

To: Williams Mich &lt;13485407@sun.ac.za&gt;

Cc: Alf Rossi

Dear Ms Williams

I hereby acknowledge receipt of your request to conduct research at Groote Schuur Hospital. Your request has been forwarded to our Medical Superintendent who deals with research request.

Kind regards

Mrs Leigh Pollio  
Public Relations Unit  
E45B, Old Main Building  
Groote Schuur Hospital  
Main Road  
OBSERVATORY, 7925  
Tel : (021) 404-2188  
Fax: (021) 404-3254

Website : [www.gsh.co.za](http://www.gsh.co.za)

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"All views or opinions expressed in this electronic message and its attachments are the view of the sender and do not necessarily reflect the views and opinions of the Provincial Government Western Cape ("the PGWC"). No employee of the PGWC is entitled to conclude a binding contract on behalf of the PGWC unless he/she is an Accounting Officer of the PGWC, or his or her authorised representative.

**From:** Kurt Maart  
**To:** Carstens, Martha  
**Date:** 6/10/04 10:05AM  
**Subject:** Re: Fwd: research proposal

Martie  
Dis goed so  
Groete

Kurt Maart  
Tygerberg Hospital  
Private Bag X3  
Tygerberg  
7505  
Tel: 021 938-5615  
Fax: 021 938-4128  
E-Mail: ksmaat@pawc.wcape.gov.za

>>> Martha Carstens 06/09/04 03:10PM >>>

Dr Maart  
Die student het nou die dag geskakel om terugvoering hieroor te kry.  
Wat kan ek sê? Martie

>>> Martha Carstens 05/13/04 03:15PM >>>

Dr Maart  
Hierdie student het voorheen al navorsing by TBH gedoen. Kan sy maar weer in Augustus kom  
onderhoude met personeel en pasiënte voer?  
Dankie  
Martie

>>> "Williams Mich < 13485407@sun.ac.za >" < 13485407@sun.ac.za > 05/13/04 11:48AM >>>

13 May, 2004

Tygerberg Hospital

Fransie Van Zyl Drive

Parowvallei

Ps x3

Tygerberg

To whom it may concern

#### RE: PERMISSION TO CONDUCT RESEARCH

I am a Masters student at the University of Stellenbosch currently studying possible multilingual policy implications in practice within the Cape public health sector. The research includes a fieldwork period of 4-6 months throughout various clinics, district and tertiary hospitals in the Cape Unicity. A Xhosa-speaking translator shall accompany me for the duration of the fieldwork. I would like to

conduct research in your setting from mid-August for a 2-4 week period. A brief outline of my research proposal has been attached to this letter. The study may be valuable in identifying the possible success of multilingual policy implementation, in contributing towards the quality of health care. I would greatly appreciate your co-operation and assistance at this time. For further enquiries, please contact me at the details provided below. For further references, contact Professor Simon Bekker at: Tel: (021) 808 2417 or E-mail: [sb3@sun.ac.za](mailto:sb3@sun.ac.za)

Sincerely Yours

Michellene Williams

Tel: (021) 510 3171

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E-mail: [13485407@sun.ac.za](mailto:13485407@sun.ac.za)